Mental Health Concerns of People Affected by Terrorism

12062
CPHE - CLIC

Painting by Sparsh Prasad, Class

SOCHARA
Community Health
Library and Information Centre (CLIC)
Centre for Public Health and Equity
No. 27, 1st Floor, 6th Cross, 1st Main,
1st Block, Koramangala, Bengaluru - 34
Tel : 080 - 41280009
email : clic@sochara.org / cphe@sochara.org
www.sochara.org

Donated by Fr. John Vattamattom on Dec. 2009

National Seminar on

Mental Health Concerns of People Affected by Terrorism

20 November, 2001
New Delhi

Organised under the auspices of
THE RAJIV GANDHI FOUNDATION

Sponsored by
EMBASSY OF FINLAND

Co-ordinated and Edited by
Dr Niraj Seth

Rajiv Gandhi Foundation, 2002.

The Rajiv Gandhi Foundation gratefully acknowledges the contribution of all the participants in the seminar, especially those who have written papers which are being brought out in this publication. The views expressed in these papers are not necessarily those of RGF.

We are also thankful to the INTERACT children and students of Springdales School, New Delhi for their efforts to help us view the issue from their perspective. The poems have been written by the children affected by terrorism whereas the paintings have been made by students of Springdales school who have supported the project in the past.

Rapporteurs:

Ms Mayura Bhatia
Ms Roopee Sahaee

COMMUNITY HEALTH CELL
LIBRARY
AND
INFORMATION
CENTRE
BANGALORE 34

MH-100
12062 P02

Cover illustration by Arshdeep Singh, Class V, Springdales school, Pusa Road, New Delhi

CONTENTS

Painting by Pranav Kumar, Class- III, Springdales School, Pusa Road.

After the death of my father

After the death of my father
Like a day after the storm
Like a house with no pillar
Everything is dark, only dark!

After the death of my father
My mother has lost her heart
She tried to go with father,
Looking at us stopped her feet.

After the death of my father
People give her wrong looks
Seeing them mother raises her hands
And tries to fight against them.

After the death of my father
Mother's eyes are full of tears
There is no day when her eyes get dry,
Seeing us, she cries and cries!

After the death of my father
Mother works day and night
Thinking that one day we will wipe her tears
She dreams for us.

After the death of my father
We never get to call;
O father ! O dear father !

Seeing someone else's father
Our mouth opens to call father
Our eyes fill with tears
But we never get to call father.

Y. Binta Devi, Age 17 years.
Manipur (Written in 2000)

Painting by Mehak Batra, Class - VI, Springdales School, Pusa Road.

God's Voice

While walking through the street,
two old women meet,
looking at me they pointed,
one said to another,
poor girl, poor girl,
she is an orphan,
in the battle of life,
she is undone.

On hearing this, I give them a smile,
let them talk,
it is their style.
But then I thought to myself,
am I really a poor one ?
Is it true that I am undone?

With tears in my eyes,
I went to my bed.
Someone touched me,
and kissed my head.
Wake up my child,
don't be wild.
If people speak wrong,
you should still be strong.
You are my dear,
for you I care.
Just then I got up,
thinking it was a nightmare.
I asked my mum, "who was that"?
She replied, "It was God's voice
my dear."

Asima Rasbid Parrey, Age 16 years
Srinagar (Written in 2001).

MENTAL HEALTH CONCERNS OF PEOPLE AFFECTED BY TERRORISM

Background note

Niraj Seth
Senior Programme Officer
Rajiv Gandhi Foundation,

The psychological dimension of terrorism is a relatively unexplored area in our country. The political, economic and global repercussions of terrorism often become the focal points of discussions while the effects of terrorism on the human mind are ignored. This is evident in the discussions held across our country following the recent happenings in USA and then Afghanistan, which have put terrorism on the international agenda.

The field of mental health care also extends to mentally healthy but vulnerable people who may become mentally ill if not protected from the adverse conditions in which they live. Increasingly, wars and resulting violence are being recognised as major contributors of mental health problems. Problems of refugees, drug trafficking and post traumatic stress disorders are some fall outs of war and terrorism. Information about prevalence and pattern of mental health disorders across the world shows that these are important public health issues.

Terrorism affects the disadvantaged more severely. Within the ambit of terrorism driven mental health problems, a further focus on women and children is needed, who are most often the survivors. A few studies conducted in areas affected by terrorism in India indicate that there has been an increase in the number of cases of people with mental health problems. Increase in the number of abortions among women and sale of tranquilizers are some other indicators of stress among people. Although there is insufficient documentation of mental health problems, there are tangible indicators to prove that the mental health of people affected by terrorism is a concern that needs to be addressed.

In a nation where the total allocation on health services is only 2% of the total budget, mental health care is unlikely to assume priority. An independent commission set up by the Voluntary Health Association of India (VHAI) in 1998 highlighted that mental health care facilities and manpower in our country is less than 1% of that in western countries. The availability of beds in mental hospitals is still vastly inadequate. Mental health care is provided mostly in non-institutional settings by families or communities. Some initiatives have been taken since 1976 in the area of community psychiatry, most notably in Bangalore and Chandigarh, but these are sporadic efforts.

Some of the salient features of the National Mental Health Programme (1982) include integration of basic mental health care with general health services; linkage to community development; involvement of voluntary agencies in mental health; prevention of mental illness and promotion of mental health. These are all well thought out features but are not

being implemented adequately. The programme further aimed at setting up of district psychiatric units. With the exception of Kerala and Tamil Nadu and to some extent Karnataka, these units are yet to be established in most States.

In India, mental health care, especially in the urban areas, is largely medical. Progress in this area has occurred in a more co-ordinated manner than in the area of non-medical mental health care. In the past decade training of psychiatrists has stepped up but training of non-medical mental health professionals has not kept pace. Specific and more focussed efforts are required. Local initiatives have been there but national level thinking is needed to take the programme forward. Further, these programmes need to be evaluated and suitably modified to make them more effective.

Another significant development has been an increased involvement of the media in general mental health issues. It has helped in demystifying the occurrence of mental health problems to some extent. However, more sensitivity is needed in dealing with the issue of terrorism. It is not uncommon to find the visual media coverage of an act of terrorism focusing on the gory details. What often goes unreported and unnoticed is the trauma faced by people following the 'event'. This affects public opinion and makes the response towards the victims of terrorism myopic.

It must be remembered that psychological interventions are not always necessary to enable people rebuild their lives. In fact, medicalisation and psychologisation of trauma have been critically viewed by some professionals. Very often family and community support enhances their resilience and gives them enough coping skills to rebuild their lives. The human costs increase if support systems are not present. On the other hand, non-recognition of problems leads to bigger problems that may precipitate into mental disorders. Assisting people with mental disorders requires more intensive interventions and therefore larger resources.

Internationally several initiatives have been taken in the war affected areas viz. Bosnia, Kosovo and Rwanda. These initiatives are well documented and also critically evaluated. There is much to learn from these experiences and suitably adapt to our cultural contexts. India has been witness to terrorism for long periods of time in many areas. The effects are chronic and have almost become part of their social and economic lives. Specific mental health interventions focussed on the victims of terrorism is fairly recent in India. Therefore, very few research studies are available and documentation is even less.

The World Health Organisation (WHO) recommends that developing countries should adopt a preventive and promotive approach towards mental health. Promotion of mental health in schools, making mental health a part of primary health care are some of the options suggested. These recommendations are based on the assumption that non-medical mental health professionals are not easily available. Due to inadequate training facilities, there is a dearth of professionals like psychiatric social workers, clinical psychologists, psychiatric nurses and school counsellors in general and especially at places where they can play an effective role.

Certain interventions undertaken recently to provide psycho-social support to people in terrorism affected areas, especially in J&K, have generated interest. This seminar explores some possibilities of interventions and invites discussion for taking similar region-specific initiatives in other areas like the North-East, Punjab, and Andhra Pradesh. It also explores possibilities of networking among individuals, organisations, mental health professionals and the funding organisations to draw a common agenda on which there can be joint collaborations. The idea is not to dilute but to synergise the efforts of those who have the willingness to work towards this cause.

SECTION I

THE SEMINAR: ISSUES DISCUSSED AND PROPOSED ACTION PLAN

Over 50 participants attended the seminar. A number of them came from the terrorism affected areas (Andhra Pradesh, Assam, Manipur, Nagaland, Punjab, J&K and Tripura). Organisations and individuals working on or concerned about this issue participated. Mental health professionals with varied training and even para counsellors (with no formal training in counselling) deliberated on the problem. The seminar was divided into 4 sessions (detailed programme is given in Annex D). The sessions focussed on different aspects of mental health of people affected by terrorism. In the last session an action plan was discussed and recommendations made to provide psycho-social support to the affected people.

Presentations were made by a few participants to highlight different issues. Their papers have been included in the second section of this publication. A few papers, not presented in the seminar, but relevant to the issue, have also been incorporated. Feedback was given by some participants even after the seminar. Their views have also been included in the report.

The presentations were followed by discussions among the participants. These sessions were chaired by Justice JS Verma, Chairman of National Human Rights Commission (NHRC); Dr Kiran Bedi, Joint Commissioner of Police; Dr RN Salhan who represented the Ministry of Health and Family Welfare and Mr Manmohan Malhoutra, Secretary-General of the Rajiv Gandhi Foundation. The chairpersons gave some valuable insights and suggestions: therefore, a few important comments made by them form a separate section of this report.

A number of significant issues emerged during the discussions. These issues have been put together. The recommendations made by the participants and the action plan emerge out of these issues. The discussion involved many of the participants, though only a few names are mentioned because specific instances and information were cited by them.

MAIN ISSUES DISCUSSED IN THE SEMINAR

Role of the State

The role of the State in addressing the problem of terrorism was discussed at length. Most participants agreed that poor governance is one of the main contributing factors for terrorism. Lack of a sense of belonging to the state and human rights violations give rise to terrorism. While the problem exists in J&K and the north-eastern states, it can arise in other states too if adequate attention is not given to the problem. Justice Verma said that the NHRC receives more than 50 percent cases from U.P. and we should therefore not be complacent about any part of the country.

The situation in J&K was focussed on more than other states. The human rights violations in Kashmir have a strong causal connection with the mental health problems of the people. People have lost faith in the judiciary where the cases lie pending for a long time. None of those who are identified as having committed an offence are convicted. It was pointed out that there are about 30 – 40,000 orphans in the state but only 5 – 6 government orphanages exist. Ms Sahba Hussain said that the Social Welfare Board in Kashmir has many schemes, but orphans and half widows whose husbands are missing for more than even ten years have not been covered under any scheme. A project had been taken up in J&K by Oxfam to publicise schemes meant for women and children. However, Mr Rasheed mentioned that inspite of meeting the State Government officials it took him six months to gather information about the welfare schemes meant for women and children. Most officials working in local agencies and government offices merely made promises for the welfare of people but never implemented them.

A different experience was cited by Ms Kamal Singh who said that by working with the Punjab Human Rights Commission, the British Council had piloted a multi agency approach in Punjab. The PHRC had acted as a hub and had brought together the police, education, social welfare, and health officials, elected leaders and various NGOs. They were also trained in teams and are running public programmes which are local area based programmes for one day. These programmes are well received by local panchayats and they want them to be repeated. Therefore, it is important to form a hub and for someone to take the lead.

Dr Bedi pointed out that power politics exists in government agencies. It is difficult for two different departments of the government to work together and therefore it was essential to find a way of bonding them together. For instance the social welfare department does not interact with the education department. Moreover they have their own schemes and way of delivery whether they work or not: But it is extremely important to work in partnership and if that kind of thinking can develop in states of our country, then there is a way forward. Different departments should also be made more accountable. As an example it was mentioned that the Social Welfare Department in J&K organises a small camp but claims big amounts from the Government as the latter doles out money for such activities.

The general opinion was that a state which is perceived at first to be insensitive to genuine grievances and then tries to counter dissatisfaction by distributing largesse does not easily improve its image. In the absence of effective and sensitive communication, no matter how good the scheme maybe, it will not be well received.

Role of NGOs

While the government agencies should not be absolved of their responsibilities, NGOs can play a role in providing a powerful bridge between government agencies and the people. In the terrorism affected areas, they could assist in implementation of welfare schemes for the women and children of both the victims of terrorism and of the terrorists. To be able to undertake this task effectively, NGOs should work together so that there is enough sharing among them. It is important to provide information to the victims about their rights so that they become aware about what they can get and know whom to approach for help. Once the NGOs and victims have information about their rights they can together approach the government and force it to perform. This will also help to reduce corrupt practices.

It was felt that networking is a long-term process and it is important that the participants continue to meet on a regular basis and support each others' efforts. Some efforts to network have been made in J&K although it was difficult to get people together. For instance a confederation of 23 NGOs has already been formed to share each other's work. Reservations were expressed by Mr Rasheed about the genuineness of all these NGOs since many of them had simply mushroomed in the recent past without any long-term plans. Ms Sofiya supported this view and said that they were trying to make the genuine NGOs part of a confederation since majority of them were not performing well. She referred to CARE, Srinagar, a group comprising networks of NGOs, people and professionals belonging to different places working for the victims, which had recently been put in place. It was suggested that the Rehabilitation Council formed in Kashmir needs to be activated as it can work as an effective hub for interaction among NGOs, government and concerned individuals.

North-East

While appreciating the seminar, all the participants from the north-eastern states stressed that the problems of people in their states have not been sufficiently addressed. A feeling of alienation and widespread unemployment were serious problems which have not been given adequate attention. Consequently people were turning towards terrorism as they were feeling alienated and neglected. It was very important to alleviate these feelings.

Making a distinction between long-term and short-term terrorism, it was pointed out that the mental health problems of people need to be addressed keeping in mind the duration of terrorism in their State. Those suffering from long-term terrorism have relatively better coping mechanisms e.g. in Nagaland and J&K. On the other hand, the effects of recent terrorism in Manipur and Assam are more disruptive.

Women and children affected by terrorism

Traumatised children may either successfully resolve their trauma or develop into an apathetic group of withdrawn persons when they grow up with a feeling of mistrust in society. Therefore, it is very important to provide support and guidance to them in their formative years. Services should be extended to the child victims of terrorism as well as to children of terrorists. At present the welfare services do not extend to the families of terrorists leaving them with limited options for the future. Adolescents and youth are more vulnerable to recruitment into a life of violence since they search for an identity that affords them status and opportunities for self-expression. Therefore their needs should be addressed too through appropriate mentioning and providing them opportunities for education and earning an income. We need to think about some of these concerns in the social; economic, and physical health domains also while thinking about mental health issues. Response to distress must address the emotional aspect as only one of the fall-outs but the reversal of the mental health problem does not lie in the psychology of the individual or the affected population alone.

Women are another vulnerable group in need of support. Many women have become pregnant in J&K as a result of sexual assault on them. They resort to unsafe and illegal means of abortions leading to both mental and physical trauma. The plight of half-widows is also very pitiable. The harsh reality is that unless their husbands are declared dead, they are not eligible to any benefits from welfare schemes. Yet the government does not declare the fate of 'missing persons'. NGOs were urged to take up the cause of this section of society also, as the number of missing persons was growing.

Mental health care

The problem at hand is of huge proportions but not much has been done in the area of mental health care. Mr Rasheed pointed out that according to one leading psychiatrist in J&K, the entire population of Kashmir is suffering from mental health problems. Yet, there was only one mental health hospital in Kashmir, which was also in shambles. There is only one psychiatrist per 2 lakh people in Kashmir. The situation in the rural areas was abysmal for which huge resources and manpower were needed.

It is extremely important to understand the psyche of the children affected by terrorism. At the same time, unless the mental health professionals are exposed to the economic, social and political problems affecting the children it will be very difficult for them to work as helpers and counsellors. If they do not understand their suffering then they would merely be acting as a physical doctor. Dr Gyaneshwar mentioned that anxiety is a common form of mental disorder in Manipur, followed by Post-Traumatic Stress Disorder (PTSD) and depression. But the mental health care system was not very sound. Patients have to go to the hospital for treatment. Dr Das from Assam mentioned that often official mental health programmes are carried out without the involvement of mental health professionals. He gave a specific example of 'Aashwas' (described briefly in the next section) a mental health programme recently launched in his State. He mentioned that their Institute was not involved in planning of the programme. Most participants agreed that the capacities of local people, interested to work in this area, need to be built. They should be supported till they feel confident to work independently.

While discussing how a mental health care programme should be developed, there were diverse views. Some participants felt that to begin with, the focus should be a district and a model should be developed through thorough assessments, interventions and evaluations. It could then be expanded to large areas. Another view was that although it was a good idea to develop a good model, the needs of people from other areas cannot be ignored. Therefore, while intensive work can be undertaken in any one district, smaller initiatives can be taken up simultaneously in other districts affected by terrorism.

It was suggested that mental health programmes should be co-ordinated through existing networks like the Indian Medical Association and the Indian Psychiatric Association.

Medical and non-medical mental health professionals

There was some discussion about the medical and non-medical professionals working for the people affected by terrorism. Many participants felt that counselling was generally effective in helping people deal with trauma and there was no need to always give medication. Others felt that although cognitive behavior therapy helped, it was important to first diagnose the problem because the cause for a disorder may be neurological. Some reservations were expressed in making use of these terms since there was a danger of establishing a hierarchy where medical personnel would take precedence over non-medical.

However, there was agreement that training facilities for the non-medical mental health professionals was inadequate. They need to be developed and enlarged. The number of such professionals in the terrorism affected states, especially in J&K and the north-eastern states where they can play a significant role, is too little. (A state-wise distribution of clinical psychologists, school counsellors and psychiatrists is given in Annexure C.)

Participants opined that universities should incorporate mental health as a topic into the curricula of B.Ed and M.Ed degree courses. While psychology was taught as a subject, there was little awareness about mental health problems and how to deal with them. Teachers should be involved in the mental health programmes since they are important leaders and opinion makers in the villages. Suitable training should be imparted to them so that they are able to address the problems of children affected by terrorism. This suggestion was supported by many participants. Recognising this need of schools, the National Institute of Public Co-operation and Child Development (NIPCCD) has in the past organised training programmes in counselling skills for teachers, where school counsellors are not easily available. This programme should be promoted in the terrorism affected areas.

Mental health of security personnel

It was pointed out that army personnel posted for a long period of time in patrolling hostile areas suffer from stress. The security personnel do not know who is hostile towards them and who is not. They are acutely aware, however, that as representatives of state authority they are disliked, even hated by the local population. They are conscious that their presence is unpopular. They face enormous pressures, not least from the need to do things that are

painful. Reports and literature indicate that there is a policy of rotating the security forces from one area to another to relieve them from a stressful environment but it is not being implemented very professionally. An NGO, Women in Security Conflict Management and Peace (WISCOMP) plans to address the issue of psychological training and re-training of the armed forces before they are posted in the Valley. However, this aspect needs to be taken up more seriously.

Research[1]

A number of participants felt there was need for research to understand the effects of terrorism on people and also to understand the factors that go into the making of a terrorist. There were no studies on the psyche of terrorist, though it is claimed that they are psychopaths, with personality disorders and anti social attitudes. It is known that suicide bombers are picked up and trained to be professional terrorist at a very young age. It is ingrained in their minds that they are specially gifted by God to carry out His mission by fighting against a particular group, which is their enemy. There is, however, no study to understand the psyche of suicide bombers who are responsible for such mass destruction.

Dr Sonpar referred to a study of 'Militancy' conducted by Prof Ravi Kapur of NIMHANS (National Institute of Mental Health and Neuro Sciences) which is based on young people who have joined the Naxalite movement and similar groups in Punjab. It gives an insight into the factors responsible for making them terrorists.

Mr Mabood referred to his experience of interacting with 8–10 terrorists who were Kashmiri locals but had crossed the border and been trained. He mentioned that there were three main reasons that forced them to take up arms. Firstly, the sheer political negligence of the State; secondly, the high rate of unemployment in the State, resulting in a feeling that they are not a part of the country; thirdly, the harassment faced by the civilian population at the hands of the terrorists as well as the security forces. Elaborating this aspect further he also referred to the questions asked by girls in different districts of Kashmir such as Doda, Budarwa, Gondu, Srinagar which suggested why the locals take up arms. "If a terrorist enters your house and at gunpoint asks you to give him food" they asked "and the next day army personnel come to your house and consider you to be part of a terrorist group, torture, molest and rape you, what would the brother in that muslim family do?" The psyche of the terrorists is developed by political, economic and social factors which cannot be ignored.

Role of Media

The media can play a vital role in addressing the psychological impact of terrorism. It was important to raise these issues in national newspapers so that people outside the affected states also become aware of the issue. Most participants felt that the entire focus of the

---

[1]A few other studies available are:

i) 'Victims of Militancy' by Pramod Kumar, Rainuka Dagar, Neerja conducted by the Institute for Development and Communication, Chandigarh for UNICEF and the Department of Relief and Resettlement

ii) Breaking the silence: 'Women and Kashmir' by WISCOMP

media was on politics. Some media agencies had highlighted issues but these were not followed by any action. Dr Jade pointed out that information pertaining to half-orphans, half-widows, problems in psychiatric hospitals, and the denial of benefits to affected people has been covered by the BBC. She said that while the government is aware of these problems, no measures were being undertaken to resolve them.

There was too much focus on violence in the media. It would be helpful to limit the news pertaining to violence for a stipulated time period. This is important as there is a need to give more information regarding hope and revival than violence in order to counter negative feelings in the minds of people.

COMMENTS BY THE CHAIRPERSONS OF THE SEMINAR

Justice JS Verma

It is very contextual to talk about terrorism these days. After September 11, there seems to be a fixation of waging war against terrorism. We should not get carried away with this and create another kind of fear among people. Normally, the word terrorism is associated with the use of the gun or any other form of violence. In fact, terrorism, is that phenomenon which results in creating any kind of fear in the mind of people as a whole or in a section of society, which affects their psyche and may influence their actions. The brave, the honest and any other common person may experience this fear. It can emanate from any source, sometimes even from a person in authority. One need not necessarily be out of power to wield a gun for the purpose of bringing about this impact. It could be as a result of abuse of power, which is far more dangerous. Therefore, terrorism should have a wider meaning.

Despite the fact that WHO has declared mental health as the theme for this year, most state governments continue to be oblivious of the Mental Health Act. People even at the highest level have to be convinced that the mentally ill are not to be kept in jails. It is not widely accepted that mentally ill need therapeutic care, not custodial care. While discussing mental health care, it should be remembered that it is not only the children of victims but also the children of terrorists who need assistance. This requires the involvement of the whole of society. While devising mental health strategies, the community has to be kept in mind. The best strategy is to empower the community with practical suggestions that assist them in developing their capacities.

Section 19 of the Human Rights Act provides the NHRC limited jurisdiction for action since it can only act on the report of the Ministry of Defence. The Commission is stressing that a written report should not be considered sufficient. It is important that the agency in question justifies the reasons for concluding that the act was not a violation of human rights. In the cases of unnatural deaths, speedy justice should be provided. NHRC has also taken an initiative of holding a consultation with NGOs working in the field of human rights, in Delhi and Bhubaneshwar. Similar consultations will be held in four other regions of the country soon. The basic aim of these consultations is to develop some joint ventures where the collective efforts of various NGOs could help to provide strong support to the victims.

Good governance, vigilant people and the active participation of society is needed to counter terrorism. This will result in potential violators becoming protectors.

Dr Kiran Bedi

I ran a programme for the children of prisoners, who were also victims of crime. There are hardly any programmes for such children and there is absence of a systems approach. I developed a programme for them about 7 years back through an NGO called India Vision.

Under this programme, prisoners' children are adopted and their needs – educational, health related and financial – are met. About 300 children are being supported through this programme. The objective of this programme is crime prevention and rehabilitation of the victims.

The DG Police of Assam, has launched a programme called Aashwas[2] . It has been planned to reach out to the children affected by militancy. It also includes sensitization of the police towards the problems of the victims. There is great scope for the law enforcement agencies to work in collaboration with NGOs. The results of such collaborative efforts have always been rewarding. It is also important to create hubs of interaction so that a collective effort creates more impact. Individual efforts by NGOs, however good they are, fail to make a difference. Even if the NGOs have diverse views they should still find a common issue to work together.

Women should be mobilised to work collectively for they can be effective in promoting global peace. There should be a media audit for controlling display of violence. Studies have shown that an overplay of violence has a negative effect both on the mind and body of children.

Dr RN Salhan

The government is aware about insufficient mental health services in our country. In the next 5-Year Plan several measures are being taken to bring about an improvement. Some of these measures are:

1. The National Commission for Children was recently set up to address the medical and psychological needs of children. It will also look into the needs of children affected by terrorism.

2. The National Mental Health Programme (NMHP) which was promulgated in 1982 has been implemented in 25 districts so far. It will be extended to 100 districts in the next 5-Year Plan. Under the district level programme there is a team of professionals (psychiatrist, social worker, nurse and psychologist) who handle mental health problems. Rs. 22.5 lakhs are given to each district to provide mental health services.

3. A Central Mental Health Authority (CMHA) was constituted in 1987 under the Mental Health Act. It has the responsibility of providing effective mental health services. The state level authorities are not functioning very effectively at present. However, these can be approached for assistance.

---

[2] More information about this programme was collected after the workshop. The programme has been developed in collaboration with UNICEF. It will have three components – a baseline study for collecting information and developing a plan of action, imparting training to the police personnel and local *nagrik* committees and finally a sensitization campaign, which will be carried out over a period of three years. The focus of this campaign will be on issues pertaining to children with special emphasis on the need to give them opportunity to grow in a peaceful atmosphere. The project was launched in November 2001.

4. Functionaries in the area of mental health are few. There are only 3000 psychiatrists in the country which is far less than the requirement. The Government intends increasing the number of seats in the medical colleges and also develop the training of para-psychiatric personnel i.e. psychologists, social workers and nurses.

5. Primary health care is a neglected field. People should be made aware of their problems and its cure. These services will be improved. The budget for providing drugs, which at present is inadequate, will be increased.

6. The total budget allocation towards mental health services in the 9th five-year plan was only 30 crores. It has been increased to 200 crores in the 10th five year plan. The Government will sanction funds to the medical colleges to upgrade their mental health services and increase their bed strength to 25.

7. The existing 37 mental health hospitals are being upgraded with an improved infrastructure. It has been proposed to shift the long stay patients in the mental health hospitals to district level hospitals. In cases where a psychiatrist is not available then any nearby psychiatrist can be given adequate remuneration to visit the hospitals at regular intervals.

8. The CMHA has directed NIMHANS, Bangalore and Institute of Human Behaviour and Allied Sciences (IHBAS), New Delhi – Institutes working in the area of mental health – to sensitise key persons including the judiciary about the Mental Health Act so that they support the mental health activities.

9. The Mental Health Act also has provision to set up State Mental Health Authorities which would be responsible for provision of mental health services. 27 States have already set these up. However, these need to be activated. Suggestions could be made to these Authorities to activate their services especially in areas affected by terrorism.

Mr Manmohan Malhoutra

Terrorism has become a buzzword in the international vocabulary. An overload of this may result in fatigue the way it has happened with poverty alleviation. The Foundation has been deeply concerned about this issue from its inception. Project INTERACT through which we assist about 1200 children affected by terrorism to complete their school education has been in existence since 1993. It is limitations of funds and not of will that prevent us from reaching out to more families. We have a sense of satisfaction that we have been pioneers in the field of mental health problems arising from terrorism.

A global campaign against war toys and war games has been started by Dr Najma Heptullah. These toys encourage a streak of violence and sow a deadly seed which creates problems for all societies later on. This campaign should be supported.

A recent news item likened the Great Depression of the 1930s. The phase was literally true to the present situation in the valley. According to the figures quoted in this news, 44 percent of the people in the Valley suffered from PTSD and anxiety disorder. Among these women and children are more vulnerable. Furthermore, there are about 40,000 orphans but only 6 orphanages to take care of them. We have a hidden human catastrophe on our hands affecting not only people in J&K but those in other states as well. Efforts should be made to bring human suffering to centre stage, and for different organisations to try and synergise their work.

SUMMARY OF THE MAIN ISSUES DISCUSSED IN THE FIRST THREE SESSIONS

Role of the State

- Make information related to the people affected by terrorism available to people e.g. names of people 'missing'.
- Efforts should be made to create awareness about the welfare schemes of the Government so that people can avail of the benefits.
- Information about the welfare schemes for orphans and half widows should be made available to people.
- The State should take measures to provide good governance to people.
- The Rehabilitation Council that was formed in Kashmir needs to be reactivated.
- There should be healthy partnership between the State and NGOs.

North-East

- Unemployment and a feeling of alienation among north-eastern states are the main reasons for terrorism.
- The long term effects of terrorism in the north-east have got deeply ingrained and need to be addressed.

Security personnel

- There is a need to understand the mental health state of the security personnel. They are also in a state of constant stress.

Militants

- The psyche of militants needs to be researched and documented.
- Children of terrorists are not covered under any existing schemes. Some programmes should be directed at this target group.

Networking

- Linkages and networks between NGOs, professionals and people working for the victims of terrorism should be formed which can become hubs of co-ordinated action.
- Working through State Human Rights Commission as possible hub centres is an option that can be explored.

Skill Development

- Capacity building of local people should be encouraged through training in basic counselling skills.
- Group intervention strategies should be developed so as to reach out to a larger population.

Research and Documentation

- There is need to conduct research on issues related to mental health in terrorism affected areas. Few research studies are presently available. Some suggested areas for research are the – psyche of terrorists, the mental health of securiety personnel, the mental health of victims of terrorism, the mental health of families of terrorists, the socio-political dimensions of terrorism and the relative efficacy of different mental health interventions.

MENTAL HEALTH PROGRAMME IN TERRORISM AFFECTED AREAS

ACTION PLAN

Recommendations given by the WHO for developing countries to develop mental health programmes include:

1. Mental health should be an integral part of general health.
2. Basic mental health services should be part of primary health care
3. Community based services should be developed.
4. Preventive approach through schools should be developed.
5. Formal mental health services should be complemented by non-medical approach.

The action plan has been developed keeping in mind that there is limited availability of mental health professionals in these areas. The recommendations of WHO form the guiding principles for the plan.

GENERAL RECOMMENDATIONS

1. The State Human Rights Commission could be the hubs of interaction among different organisations including NGOs, State Commissions for Women, State mental health boards, government departments, mental health professionals and other existing networks like the Indian Medical Association, Indian Association of Psychiatrists, Indian Association of Clinical Psychologists.
2. There should be greater interaction and sharing of experiences among organisations interested to work in regions affected by terrorism.
3. In view of the constraint of availability of mental health professionals in the terrorism affected areas, others like teachers, PHC workers could be imparted training in basic counselling skills and group interventions. The objective should be to undertake local capacity building so that the efforts are sustained.
4. The Government should make information related to 'missing persons' and the victims of terrorism available and easily accessible.
5. The north-eastern states should be given more attention and mental health programmes suitable for their needs should be developed.
6. Families of terrorists should be provided some social support which, at present, is not available.
7. The Government should develop better training facilities for non-medical mental health professionals – counsellors, social workers etc.
8. The mental health of the security personnel should also be addressed because they too are under great stress.

9. More research needs to be undertaken to understand the socio-political context of terrorism, the psyche of terrorists and the effects of terrorism on mental health of people.
10. None of the programmes taken up by organisations can be implemented on a long-term basis without the support of Government. Successful initiatives by them should be incorporated in the Government programmes.

Objective

To develop a comprehensive mental health programme in terrorism-affected areas by involving different agencies.

Specific Objectives

1. To develop local resources (teachers, PHC workers, general practitioners etc.) to address the mental health issues
2. To provide capacity among the para-counsellors through regular training and in-service training
3. To integrate the programmes in the state/centre units
4. To promote research and documentation of issues related to mental health
5. To enhance awareness of these issues through the media.

Strategy

- A broad strategy would entail building on the existing mental health programmes in the area by tapping the local resources.
- The programmes will have to be developed keeping in mind the local needs and cultural variations.
- Networking among different stakeholders including networks of professionals, NGOs, government agencies, funding agencies and interested individuals would be enhanced by information sharing.
- Preventive mental health programmes will be undertaken through schools, community networks, primary health centres.
- Advocacy programmes will be taken up for activating the provisions made under the National Mental Health Programme in terrorism affected areas especially the district mental health centres.
- Mental health interventions both medical and non-medical will be taken up.

TIME FRAME

Short term plan – 24 months

Areas of intervention – Nagaland, Assam, Manipur, Tripura, J&K, Punjab, Andhra Pradesh.

Probable partners in the programme – WHO, UNICEF, MSF, British Council, OXFAM, Save The Children, RGF, Indian Association of Psychiatrists, Indian Association of Clinical Psychologists, Indian Association for Family Therapy, Indian Medical Association (IMA), Consultants (Mental health).

Stakeholders – Mental health professionals – medical and non-medical, PHC workers, NGOs, School/University teachers, Media, Development agencies, Interested individuals, Relevant Central/State departments.

Phases	Objectives	Activities	By Whom	Time frame
Phase I Preparation	Identification of specific areas of intervention and interested resource agencies/ individuals	• Mapping of the affected areas • Identification of stakeholders at the local level	• IMA, Indian Association of Psychiatrists, NGOs, VHAI	1– 3 months
Phase II Intervention phase	Interventions in a co-ordinated manner to involve stake-holders in addressing the problem more effectively.	• Preparation of training modules for different target groups • Training of GPs, PHC workers, para counsellors, school teachers, others. • Intervention by trained persons • Refresher training/ follow-up • Exchange of information among professionals • Research and documentation • Advocacy	• Consultants • Trainers identified/ decided by the core group • Same as above • Development agencies, networks • Fellowships • Media, voluntary organisations – national /international	• 1–3 months • 3–9 months • 3–12 months • 5–18 months • 9th and 18th months • 1–18 months • 1–18 months
Phase III Institutionalisation phase	Incorporating the initiatives taken in the 2nd phase existing programmes	• Setting up of district mental health centres • Incorporating the interventions in on going programmes of NGOs, family welfare programmes	State government • NGOs	• 18–24 months

Long term Plan: Setting up of a central mental health training institute for imparting training to non-medical mental health professionals – psychiatric social workers, psychiatric nurses, school counsellors, clinical psychologists.

SECTION II

REFUGEES, THERAPISTS AND TRAUMA: SYSTEMIC REFLECTIONS*

Papadopoulos, R.K.
Professor at the University of Essex
Consultant Clinical Psychologist at the Tavistock Clinic, UK

In recent times, the proliferation of vivid media coverage of military conflicts and their consequences has been accompanied by a parallel propagation of psychological theories attempting to explain these painful phenomena. Although there are numerous and varied theories about the related themes of conflict, violence, power, identity, ethnicity, trauma, etc, it seems that there is unanimity about one prevailing belief according to which almost everybody affected by these events is 'traumatised'. The term 'trauma' has lost its specific psychological meanings and has become synonymous with painful experience; there is a widespread tendency to call 'traumatic' most disrupting, distressing, disturbing, unsettling, tragic, hurting experiences. Whatever sharpness its psychological definitions were attempting to provide has been lost since the word 'trauma' was appropriated by journalists, politicians, social commentators, and demagogues and used indiscriminately to render respectability to their claims. It sounds more authoritative, respectable and convincing when one says that a person had been 'traumatised' by an event, instead of saying that the person had been 'shaken' by it. The power of the word 'trauma' lies in its widespread (and seeming) intelligibility which, of course, is deceptive because if pressed, those who use it would find it difficult to define what they mean by 'trauma'.

This means that there is a prevalent and indeed dominant discourse in society which makes people hold the conviction that when a person is exposed to adversity automatically he or she is traumatised. Inevitably, refugees have not escaped this indiscriminate precept and hence there is a particularly strong belief that most refugees have been traumatised. Moreover, the 'refugee trauma' discourse tends to be restrictive because it emphasises only one segment of the wide spectrum of the refugee experience. This spectrum could be divided into at least four phases which have been identified as 'Anticipation' (when people sense the impending danger and try to decide how best to avoid it), 'Devastating Events' (this is the phase of actual violence, when the enemy attacks and destroys, and the refugees flee), 'Survival' (when refugees are safe from danger but live in temporary accommodation and uncertainty), and 'Adjustment' (when refugees try to adjust to new life in the receiving country) (Papadopoulos, 2000b; in press 1, in press 2). Unmistakably, the 'refugee trauma' discourse privileges the phase of 'devastating events' and blatantly downplays or even ignores the consequences of the adverse nature of the other phases.

---

* First published in Context: the magazine of the Association for Family Therapy, No. 54, April, pp 5–8. Special Edition on REFUGEES edited by Gill Gorell Barnes and Renos Papadopoulos.

As we know, a large number of refugees may not have even experienced that phase at all, fleeing without having any direct violent contact with the enemy. Yet, the tyrannical nature of the 'refugee trauma' discourse induces both refugees and workers to veer towards that direction, masking the painful impact of all the other phases.

So, what is trauma and how can we understand its connection with refugees? First of all, trauma, in Greek, means wound, injury and it comes from the verb 'to pierce'. However, in a recent etymological investigation (Papadopoulos, 2000b; in press2) it was found that the root verb is 'to rub' and, in this context, in ancient Greek it has two meanings: to rub in and to rub off, to rub away. Thus, according to the original definition, trauma is the mark left on a person as a result of something being rubbed onto him or her. Then, depending on the way that the rubbing took place there are two different outcomes. More specifically, when a powerful and intense experience is rubbed onto a person, the 'trauma' could be either an injury (rubbed in) or a new life, where the person can start with a clean slate and with the previous priorities erased (rubbed off). The first meaning of trauma is well known and it is the one privileged by the 'refugee trauma' discourse; although prima faciae the second one may appear puzzling, it is not unfamiliar with those who work with refugees. The 'rubbing off, away' meaning of trauma refers to the common reaction people also have following a difficult and intense experience, when they realise that, despite the excruciating pain, disorientation, disruption, etc, their lives were also marked by a renewed sense of priorities and meaning in life. Needless to say, the 'refugee trauma' discourse creates no space for any indications of the second meaning to emerge. Perforce, this imperceptible skewing leaves trauma firmly located within pathological parameters.

Left within an exclusively pathological context, trauma creates further concerns. Essentially, trauma, according to the 'refugee trauma' discourse, is a linear concept which implies a clear causal-reductive relationship between external events and intrapsychic consequences. As such, it ignores systemic complexities such as the relational nature of the events' impact among family, community and ethnic group members, as well as the effects of the wider societal discourses which colour the meaning, emphasis and quality of events and experiences. Ironically, as trauma tends to polarise positions and reduce complexities to simplistic formulae within individuals and groups, so does the refugee-trauma discourse impose a simplistic connection between the events and psychological experience.

This is an important consideration which should mobilise our epistemological awareness to discern the various discourses that get intermingled around this most delicate issue. As argued elsewhere (Papadopoulos, 1998; Papadopoulos and Hildebrand, 1997), under the pressure of the unbearable pain and multiplicity of losses in these circumstances, we tend to confuse at least three sets of discourses: moral and ethical, clinical and pathological, with socio-political and historical ones. The usual result is that we tend to confuse the justified abhorrence of the atrocities (which are considered 'the cause' of the trauma) by pathologising the persons who survived them. However paradoxical this may be, this is usually the case. In our effort to express our justified condemnation of the individuals, groups and policies that lead to political oppression and crimes against humanity, we offer as 'proof' the fact that people have been traumatised by these despicable actions. In doing so, we ignore all systemic considerations of how people process experiences and,

unwittingly, we end up doing violence to the very people we want to help. Thus, we tend to psychologise political dimensions and pathologise both evil actions as well as human suffering (Papadopoulos, 1997; 1998; 2000a).

This argument should not give the erroneous impression that the refugee suffering is either ignored or even idealised. On the contrary, once we locate it in the context of clearly delineated but interacting systems, we can proceed in a more prudent way to address the refugee predicament.

Thus, if being a refugee is not a psychopathological category, not even a psychological condition, how can we then approach it as therapists? To begin with, let us be reminded that the term 'refugee' has two meanings: colloquially, refugees are people 'taking refuge, especially in a foreign country from war or persecution or natural disaster" (OED). Legally, (under the International Refugee Convention, 1951, article 1A.2) a refugee is a person who has 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion'. The difficulties around refugee issues begin with the very term 'refugee'. Strictly speaking, and using the legal definitions, the term refugee has no ontological status because when persons enter a country seeking asylum, they are called 'asylum seekers' (not refugees) and as soon as asylum is granted, they are no longer refugees but enjoy all the rights of all citizens of the receiving country.

From a systemic perspective, we will need to approach refugees mindful of two perspectives: the 'essentialist' perspective reminds us that refugees have sustained a multiplicity of actual losses and they have been exposed to many painful situations; this perspective helps us realise the complexity and the multidimensional nature of the refugee situation – regardless of whether they have any psychological needs, refugees definitely have financial, medical, educational, social and numerous other concrete needs and we cannot afford to minimise these. In addition, a 'constructivist' perspective focuses on the ways that refugees define themselves, their needs and their very own experiences (as well as the ways in which psychologists perceive all these and their own role as helpers), in the context of the wider socio-political constructs. This perspective emphasises the multifaceted influences that shape the refugee experience. For example, depending on the country of origin and the historico-political circumstances, the public opinion in the receiving country selectively emphasises aspects of the plight of a given group of refugees which affects the way helpers respond.

Against this background, it would be useful to keep in mind the following:

• As being a refugee is not a pathological condition, what is the therapists' entitlement? How should we position ourselves in relation to them, to their difficulties and to the network of professionals? Can we intervene if not asked to do so? How can we respond to their undeniable suffering without pathologising it? How can we appreciate their predicament without psychologising its political dimensions? Although there are no clear and general recipes to these answers, bearing them in mind allows us to create appropriate parameters for our work (Papadopoulos, 1999a).

• Relationships within refugee families undergo radical transformation and role reversals are not uncommon. For example, as children usually assimilate faster than their parents, they acquire new responsibilities (even looking after their parents); mothers tend to attain new authority due to their involvement with their children (at school and in the neighbourhood) and fathers seem to become more isolated as they lose their traditional position – they become more vulnerable especially without the authority of the work status they had in their home country. (Papadopoulos, 1999a; Papadopoulos and Hildebrand, 1997). The therapist's task is, therefore, to enable the family not only to remember this change of roles but also facilitate the understanding of its impact for all family members.

• It is usually considered that refugee families are torn between two 'oppositional discourses' with regard to their loyalty and overall orientation (Papadopoulos and Hildebrand, 1997). On the one hand, they wish to remain loyal to the culture, language, traditions of their home country and to honour the past but, on the other hand, they want to grasp the opportunities open to them in the receiving country and to build the best possible future in their new home. Moreover, this conflict is often perceived as being between the age divide in the family, with the older generation holding on to the past whilst the new generation races forth, accepting the new life and being scornful of the ways of the old country. Research has shown that this view is not entirely true and the situation is fairly complex: 'far from having detrimental effects, the oppositional discourses may enrich and assist families to live more creatively' (Papadopoulos and Hildebrand, 1997, pp. 232–233). Also, the oppositionality does not follow rigidly the age divide. More specifically, it was found that the family as a system seems to assign roles to family members, almost arbitrarily, so that at every given time there is a relative balance between both sides. Thus, although grandparents by and large are the holders of the traditional values and customs of their home country at the same time they were found to do their utmost to assist their grandchildren to do well and make the best of the opportunities in their new country. 'Grandchildren were also not exclusively oriented towards their new world in the UK but had moments when they privileged their pre-refugee world'. For example, 'a teenage girl, although she seemed preoccupied with fitting in with her school friends in appearance, mannerisms, music preferences etc, also spent time with her grandmother learning to cook ... specialities' from their home country (Papadopoulos and Hildebrand, 1997, p. 227). This means that therapists should avoid following stereotyped perceptions but enable refugee families achieve creative ways of interacting.

• Families are dynamic entities that maintain a balance between stability and change. However, in times of great upheaval (such as when they become refugees) this balance is threatened and refugee families tend to go either for too much rigid stability or for uncontained change. Moreover, with the appropriately excessive focus on external adversity, they tend to overlook the dynamics of their family interrelationships and this may make them vulnerable to destructive family conflicts.

• Returning to the idea of trauma as 'wound', it may be useful to ponder on an important recent development in medical traumatology. Medical specialists have become aware of the puzzle that if left unattended and in cold conditions, severely traumatised individuals

did not bleed to death as previously expected. This phenomenon was particularly evident during the war in the Falkland islands when soldiers with multiple and severe wounds were left alone for long time in the cold. Despite predictions, the death rate of these soldiers was unexpectedly low, and after much research it was found that the cold conditions enabled the body to develop its own self-healing mechanisms. This means that our impulse to wrap up a wounded person paradoxically prevents the body from attending to the trauma by activating certain self-healing mechanisms. This finding has radicalised the field of medical traumatology and the new approach attempts to facilitate rather than block the organism's response by, *inter alia*, introducing measured hypothermia. This development should be most instructive and indeed inspirational for therapists dealing with psychological trauma, too. Systemically speaking, it could be argued that by positioning ourselves so that we are aware of both the pain, disorientation and vulnerability as well as the inherent resilience of the individual, family and group we can enable ourselves to function in ways that can be empowering to the survivors. If we fail to do this, inevitably we will lock the refugees in pathological positions with dire consequences.

- One specific way of facilitating the inherent resilience is the attention to what has been referred to as a 'storied community' (Papadopoulos, 1999b). It is essential to explore ways of encouraging the emergence of family and community narratives of overcoming adversity without masking the negative and disturbing consequences. This needs to be undertaken with the utmost respect for the specificities of all involved persons as well as consideration for the contextual circumstances and overlapping systems.

- The hypothermia image could have additional meaning for and application in working with refugees. Under conditions of deprivation, and with a multiplicity of losses, individuals, families and communities seem to 'freeze up' and the repertoire of their functioning becomes restricted. This state of 'frozenness' (Papadopoulos, 1997) can be seen either as a pathological condition and consequently we assign ourselves the task of changing it, or we can appreciate it as a temporary and appropriate response that the organism, family or community resorts to in order to survive. In the state of frozenness, an individual, family and community limit their activity to the bare essentials and conserve energy which helps them develop a reflective and meditative stance. This temporary withdrawal can provide unique vantage points from where to review and reassess their lives, their past, present and future; it may also assist them by digesting the impact of their losses, by creating the respectful stance to mourn the dead, by enabling them to regroup and direct their energy more appropriately. However, if one were to panic and see this important phase only as unhelpful disorientation rather than also as an opportunity for re-orientation, then this unique prospect will be lost. Instead, everybody (refugees and helpers) will seek the impulsive comfort of warmth, thus blocking the activation of self-healing processes which can develop within the phase of temporary frozenness. Within the repertoire of every community there are narratives of how the sanctioned space for this kind of frozenness can be developed and maintained as well as how it can enable further growth. The task of therapists is to enable such storied communities to emerge rather than imposing our own psychological theories. Systemically, therapists can rely on the dual need of all systems for both stability and change and refrain from attempting impulsively to change

everything that does not conform to our own theoretical models of normality. Finally, the process of "thawing" requires an approach based on the uniqueness of the individual and context. 'Thawing is a delicate process which may damage the frozen item if not used appropriately.' (Papadopoulos, 1997, P.15)

• Considering the multiplicity of losses that refugees experience, there are two losses that tend to be invisible and hence ignored: the first is of what could called the 'mosaic substratum' of our identity and the second is a person's ability to 'read life' (Papadopoulos, 1997). The first refers to the imperceptible network of elements which form the base on which the tangible aspects of our identity stand. These elements, which form a unique mosaic, tend to be experienced only when we lose them. They include 'the fact that we belong to a country, that our country exists, that we belong to a certain cultural and language group and are used to certain sounds, that we belong to a certain geographical landscape and milieu, that we are surrounded by particular types of architectural designs' (Papadopoulos, 1997, p.15), etc. The loss of this mosaic leaves the individual with an inexplicable gap and a sense of unreality and it is useful for therapists to assist refugees to connect with some of these losses. The second loss referred to here is the ability to 'read life' and it concerns the predictability that we get accustomed to in living our everyday lives. Ordinarily, we have some idea as to which situations are dangerous and which are not, when to behave in which way, what range of possibilities to expect from each set of circumstances, etc. All this familiarity creates a sense of security in us because we feel we know how to 'read life'. It is precisely this confidence that refugees are likely to lose as a result of the totality of their losses, disorientation, frozenness etc. This kind of loss is particularly difficult because it is also not easy for refugees to grasp and it creates a sense of uneasiness and pervasive unsafety. Therapists should again help refugees become aware of this loss and bear the resulting temporary disorientation.

• One central dilemma in working with refugees is whether to treat them as ordinary people or as a special category that requires specialist knowledge and expertise. Practitioners in the field are divided on this issue. Some follow the dictum that refugees react normally to abnormal circumstances and therefore there is nothing uncommon about their predicament, whereas others concentrate on the specific impact of the multiple losses and suffering that they endure and argue for a highly specialist approach. This dilemma is experienced by refugees themselves who, on the one hand, expect special treatment and on their other hand yearn to become again ordinary people and get on with their lives without specialist attention. Systemically speaking, practitioners are used to working at different levels appreciating the complexities of their interaction. In principle, therapists could position themselves in a context that can appreciate the reality of both perspectives thus avoiding oversimplifications.

• Finally, one of the most difficult dynamics in working with refugees is the closed system of victim-saviour that refugees and therapists can easily co-construct. Essentially, if the refugee is pathologised and seen exclusively as just a victim, invariably the therapist is likely to occupy the saviour role. However, this system is not limited to the dyad of victim-saviour because saviours do not save victims without an attempt to protect them from their violators. Thus, the systemic triangle of victim-saviour-violator tends to keep

MH-100
12062 P02

perpetuating itself creating endless variations with different people in the same roles. The most common variation is for the "victim-saviour couple to keep on producing increasingly more enemies that they will need to defend themselves against, such as the managers of the therapists' services and other individuals and bodies that do not offer the kind of unconditional support that the couple expects and demands." (Papadopoulos, in press 2)

Work with refugees creates a lot of difficulties some familiar, others specific to the refugee situation. Working systemically can enable therapists to identify and address some of these traps. The refugee trauma discourse is particularly complex and it requires further exploration. Trauma is not just an intrapsychic condition which is created in a linear and causal-reductive way by violent events. It is also a social construction and it fits within wider social constructs and the particular ways that certain mental health services are developed and maintained. Certain types of service provision and referring networks may also perpetuate a pathologised version of the refugee trauma discourse.

Ultimately, we should not forget that human suffering is not always synonymous with psychological trauma. Refugee families, despite their disorientation, pain, and losses may also be extremely resilient and it is important that we acknowledge this and include it in the ways we relate to them.

REFERENCES

Papadopoulos, R.K. (1997).Individual identity and collective narratives of conflict. Harvest: Journal for Jungian Studies, vol. 43, no.2, 7–26.

Papadopoulos, R.K. (1998). Destructiveness, atrocities and healing: epistemological and clinical reflections. The Journal of Analytical Psychology, vol. 43, no. 4, 455–477.

Papadopoulos, R.K. (1999a). Working with families of Bosnian medical evacuees: therapeutic dilemmas. Clinical Child Psychology and Psychiatry, vol.4, no.1, 107–120.

Papadopoulos, R.K (1999b). Storied community as secure base. Response to the paper by Nancy Caro Hollander 'Exile: Paradoxes of loss and creativity'. The British Journal of Psychotherapy, vol.15, no.3, 322–332.

Papadopoulos, R.K. (2000a). 'Factionalism and interethnic conflict: narratives in myth and politics'. In 'The Vision Thing. Myth, Politics and Psyche in the World' edited by Thomas Singer. London and New York: Routledge.

Papadopoulos, R.K. (2000b) A Matter of Shades: Trauma and Psychosocial Work in Kosovo. In Psychosocial and Trauma Response in War-Torn Societies; the Case of Kosovo, edited by N. Losi. Geneva, I.O.M.

Papadopoulos, R.K. (in press1). 'Narratives Of Translating – Interpreting With Refugees; The Subjugation Of Individual Discourses'. In Working with Interpreters in Mental Health, edited by Rachel Tribe and Hitesh Raval. London: Routledge.

Papadopoulos, R.K. (in press2). 'But how can I help if I don't know ?' Supervising work with refugee families. In Aspects of Supervision: a Systemic Perspective, edited by David Campbell and Barry Mason. London: Karnac (in press).

Papadopoulos, R.K. and Hildebrand, J. (1997) 'Is Home Where The Heart Is? Narratives of Oppositional Discourses in Refugee Families'. In Multiple Voices: Narrative in Systemic Family Psychotherapy, edited by R. Papadopoulos & J. Byng-Hall. London: Duckworth, pp. 206–236.

MENTAL HEALTH OF PEOPLE AFFECTED BY TERRORISM

Dr Pradeep Agrawal
Senior Psychiatrist
Lady Hardinge Medical College &
Sucheta Kriplani Hospital
New Delhi

I have been working for the torture victims through an NGO called Shubhodaya Centre for Rehabilitation of Victims of Torture and Violence. The Centre primarily works with the refugees in India and also the victims of torture within our country. I have also been associated with the INTERACT project of the Rajiv Gandhi Foundation.

Terrorism has existed in the world for decades. It was only after September 11 that more focus was given to this issue. Governments have programmes for the victims of terrorism – usually in the form of providing monetary assistance. Among the civilians it is difficult to find people to work with this target group since nobody wishes to associate with them, out of fear. Therefore the role of RGF to work with the people affected by terrorism is very important.

What is terrorism?

It is the use of force or violence against a person or property in violation of the criminal laws in the country for purposes of intimidation, coercion or ransom. Terrorists use threat to create fear among the public. By using these methods they try to convince citizens that their government is powerless. They also indulge in these activities to get imediate publicity.

Terrorism is of two types

Domestic – It involves groups and individuals whose terrorist activities are directed at ailments of the government or population without foreign direction. They usually call themselves freedom fighters. The activities are carried out without receiving any financial aid from outside.

International – It involves groups or individuals whose terrorist activities are foreign based and are directed by people outside the boundaries of that country.

Nature of weapons used – In addition to the fire arms and ammunition, the following weapons are used by terrorists:

I. **Chemical weapons** –The use of these weapons incapacitates people. Since these are odourless they are difficult to detect. These can destroy crops and can have prolonged effects lasting for days. USA is spending 11.1 billion dollars to counter threats of these weapons. There has been a threefold increase in the allocation of funds to counter these threats although the numbers of attacks using chemical weapons are far less in number.

II. **Nuclear weapons** – These are easy to carry can cause mass destruction.

III. **Suicidal squads** – Traditionally suicide terrorism was viewed as a problem affecting Middle East and South Asia, but now it has spread all over the world. The incidence of suicidal terrorism has increased in the past few years. There are religious and secular terrorist groups that are capable of using suicide terrorism against their government and foreign governments. People who are part of these squads do not have the fear that can prevent them from committing these attacks. There is readiness to destroy oneself for a 'cause'. Several countries around the world have experienced this form of terrorism. The motivation to undertake these attacks may be based on several factors. It could be religious, monetary or based on some ideology. Women are increasingly being used in these attacks. It is estimated that 30 percent suicide attacks in Sri Lanka have been carried out by women.

Torture

Torture and terrorism are two sides of a coin because the use of both these forms of violence affects the common man. Torture is a deliberate and systemic infliction of physical and mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, make confession or for any other kind of reason. The use of force by the police to extract confessions is a form of torture. In terrorism also the act is intentional although they may give a cause – freedom, fighting injustice or to solve a law and order situation. The difference between torture and terrorism is that in the former it is the people in authority who commit the act of violence whereas the latter is carried out by those not in the government. Problems of people in both cases are similar.

Physical, psychological and sexual forms of torture or terrorism are used. Usually people do not come and protest against it because they do not have the confidence that the government will be able to protect them. e.g. in the naxalite affected areas people believe that the government does not have the machinery to control the activities of the naxalites so they do not openly come out against it. There are some exceptional cases. For instance recently in J&K *'burkhas'* (a long robe worn by women which covers the face also) were made compulsory for women to wear. However, when people collectively protested against this, the *'fatwa'* (order) was withdrawn.

Talking about international terrorism, earlier INTERPOL was not much concerned about terrorism. In 1985 they created a special group to control international terrorism. It has brought out a manual for dealing with terrorism and is forming networks to deal with it.

Dealing with children affected by terrorism

Children, even though not living in areas affected by terrorism have access to different forms of violence through the media. While the adults can cope with what is shown, children find it difficult to do so. They have several questions on their minds, which need to be answered however irrelevant these may appear to the adults. Children also have the tendency to repeat their questions. Adults need to handle these patiently and not confront their defense mechanisms. They tend to personalise things e.g. the attack may be made on them. We should try and understand this anxiety of theirs and provide them with opportunities to express themselves through activities like painting, poems, plays

etc. Children learn a lot from their parents. We should also be watchful of what we say and discuss before them.

Those affected more acutely may develop certain physical symptoms, which should not be ignored. Such children should be identified and referred to mental health professionals. It should be remembered that PTSD is not the only form of mental health problem arising out of terrorism that should be discussed. Other symptoms should be recognised and dealt with appropriately.

Helping children cope after terrorist attack

- Create an open and supportive environment where children can ask questions.
- Give children honest answers and information.
- Use words and concepts children can understand.
- Be prepared to repeat information and explanations several times.
- Acknowledge and validate child's thoughts, feelings and reactions.
- Be reassuring but do not make unrealistic promises.
- Remember that children tend to personalize situations.
- Help children find ways to express themselves.
- Avoid stereotyping groups of people by country or religion.
- Children learn from watching their parents and teachers.
- Let children know how you are feeling.
- Don't let children watch excess of TV with violent or upsetting images.
- Help children establish a predictable routine and schedule.
- Don't confront child's defenses.
- Coordinate information between home & school.
- Children with previous experience of trauma are more vulnerable to prolonged or intense reaction(s) to recent tragedy.
- Monitor for physical symptoms including headaches and stomach aches.
- Children pre occupied with war, terrorism or fights should be evaluated by a trained health professional.
- Help children reach out and communicate with others.
- Let children be children.

Stress management for health care providers

- Communicate clearly and in an optimistic manner.
- Encourage health care providers to monitor themselves and each other.
- Ensure regular breaks from tending to patients.
- Some people may feel guilty if they have fun or enjoy themselves, while others are suffering. Correct them.
- Establish a place where providers can talk to their colleagues.
- Encourage contact with loved ones and activities for enjoyment and relaxation.
- Hold department meetings and keep people informed of plans and events.
- Use hospital newsletter to recognise success.
- Consider establishing awards.
- Establish support programme for family of staff.

MENTAL HEALTH PROBLEMS OF PEOPLE AFFECTED BY CONFLICT IN INDIA: POSSIBLE INTERVENTIONS

Dr K Krishna Murthy
Institute of Medical Health,
Hyderabad.

Background

Stress is the common denominator for people residing in areas of conflict. Stress is a complex concept and can be defined as any circumstance that threatens or is perceived to threaten one's well-being and thereby tax one's coping abilities.

The threats taxing one's coping abilities could be for example

1. Immediate physical safety
2. Long range security
3. Self-esteem
4. Reputation
5. Peace of mind
6. And many other things that one values.

Stress Lies in the Eye of the Beholder

Human beings usually assess the human situation in daily life and make an appraisal of the stress. Lazarus and Folkman (1984) distinguished between primary and secondary appraisal.

Primary appraisal is an initial evaluation of whether an event is

1. Irrelevant to you
2. Relevant but not threatening
3. Stressful

When an event is viewed as stressful, individuals are likely to make a secondary appraisal, which is an evaluation of our coping resources and options for dealing with the stress.

Major Types of Stress

The 4 major types of stress are

a) Frustration stress: Occurs in any situation in which the pursuit of some goal is thwarted.
b) Conflict stress: Occurs when two or more incompatible motivations or behavioral impulses compete for expression.

It could be when:

I. A choice must be made between two attractive goals.
II. A choice must be made between two unattractive goals.

III. A choice must be made about whether to pursue a single goal that has both attractive and unattractive aspects. This is the most stressful.

c) Change stress: Refers to life changes and any noticeable alterations in one's living circumstances that require re-adjustment.

d) Pressure stress: Involves expectations or demands for a person to behave in a certain way.

Types of coping strategies

Coping refers to active efforts to master, reduce or tolerate the demands created by stress.

Coping Strategy	Example
Active coping	To take additional action to get rid of the problem.
Planning	To try to come up with a strategy about what to do.
Suppression of competing activities on this.	To put aside other activities in order to concentrate
Restraint coping	To force one self to wait for the right time to do
Seeking social support for instrumental reasons	To ask people who have had similar experiences what they did.
Seeking social support for emotional reason	To talk to some one about how we feel
Positive reinterpretation and growth	To look for something good in what is happening.
Acceptance	To learn to live with it.
Turning to religion	To seek God's help.
Focus on and venting of emotions	To get upset and let emotions out.
Denial	To refuse to believe that it has happened.
Behavioral disengagement	To give up the attempt to get what one wants.
Mental disengagement	To turn to work or other substitute activities to take one's mind off things
Alcohol-drug disengagement	To drink alcohol or take drugs in order to think about it less.

Mental Health problems of people residing in areas of conflict

Hans Selye gave us the general adaptation model of the body's stress response, consisting of three stages: alarm, resistance and exhaustion. When all the coping strategies used by people residing in areas of conflict fail, mental health problems arise. The persons most affected are women and children.

The common mental health problems of people residing in areas of conflict are:

1. **Acute stress Disorder and Post -Traumatic Stress Disorder (PTSD)** – The person experiences, witnesses, or is confronted with an event or events that involve actual threatened death or serious injury, or a threat to the physical integrity of self or others. The person's response involves intense fear, helplessness or horror.

The dissociative symptoms of the person are:

I. A subjective sense of numbing, detachment, or absence of emotional responsiveness
II. A reduction in awareness of his or her surrounding (e.g. being in a daze)
III. Derealisation
IV. Depersonalisation
V. Dissociative amnesia (e.g. inability to recall an important aspect of the trauma).

The traumatic event is persistently re-experienced in at least one to the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience, or distress on exposure to reminders of the traumatic event.

There is marked avoidance of stimuli that arouse recollections of the trauma (e.g. thoughts, feelings, conversations, activities, places, people). Inability to recall important aspects of the trauma.

a) Feeling of detachment or estrangement from others
b) Restricted range of affect (e.g. unable to have loving feelings)
c) Sense of foreshortened future (e.g. doesn't expect to have a career, marriage, children, or a normal life span).

Marked symptoms of anxiety or increased arousal (e.g., difficulty in sleeping, irritability, poor concentration, hyper-vigilance, exaggerated or startled response and motor restlessness) are observed. There is impairment in social and occupational, or other important areas of functioning. It impairs the individual's ability to pursue some necessary tasks, such as obtaining necessary assistance or mobilising personal resources by telling family members about the traumatic experience.

The disorder is called Acute Stress Disorder if it occurs within 4 weeks of trauma. It lasts for a maximum of 4 weeks and Post-Traumatic Stress Disorder : if the duration symptoms is 3 months or more. It can have a delayed onset.

2. **Depressive Mood Disorder:** Mood is a sustained emotional tone perceived along a normal continuum of sad to happy. These are characterised by abnormal feelings of depression or euphoria with associated psychotic features in some severe cases.

3. **Malingering and Factitious Disorder:** Symptoms are deliberately and consciously simulated by patient. May be psychological, e.g., hallucinations or physical, e.g. pain (Factitious). Voluntary production of physical or psychological symptoms in order to accomplish specific goal, e.g. to receive insurance payments, avoid jail term or punishments (Malingering).

4. **Adjustment disorder:** Which is the development of emotional or behavioural symptoms in response to an identifiable stress occuring within three months of onset of the stresser. Acute if lasts less than 6 months and chronic if more than 6 months.

5. **Bereavement** reactions follow loss of loved persons or objects.

6. **Somatoform Disorder:** Where the person complains of several/multiple somatic bodily complaints not limited to somatic organ or system not caused by common medical disorder. Somatoform pain disorder is a preoccupation with pain in the absence of physical disease to account for its intensity. It does not follow a neuroanatomical distribution. Stress and conflict may closely correlate with the initiation or exacerbation of the pain.

7. **Conversion Disorder** is characterised by one or more neurological symptoms associated with psychological conflict or need, not physical, neurological or substance-related disorder.

8. **Dissociative Disorder with Amnesia** is characterised by psychologically induced loss of memory or consciousness, identity or perception of the environment. Underlying brain disease is absent.

9. **Problems in children**

a) Grief and Bereavement reactions

b) Conduct problems in children: Manifested by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age appropriated societal norms or rules are violated.

e.g. Aggression to people and animals

- Often bullies,threatens or intimidates others.
- Often initiates physical fights.
- Has used a weapon that can cause serious physical harm to other (e.g. a bat, brick, broken bottle, knife, gun).
- Has been physically cruel to people.
- Has been physically cruel to animals.
- Has stolen while confronting a victim (e.g. mugging, purse snatching, extortion, armed robbery).
- Has forced some one to sexual activity.

Destruction of property:

- Has deliberately engaged in fire setting with the intention of causing serious damage.
- Has deliberately destroyed others property (other than by fire setting).

Deceitfulness or theft:

- Has broken into someone else's house, building or car.
- Often lies to obtain goods or favours or to avoid obligations (i.e. 'cons' others).

- Has stolen items of non-trivial value without confronting a victim (e. g., shop lifting but without breaking or entering, forgery).

Serious violations of rules:

- Often stays out at night despite parental prohibitions, beginning before age 13 years.
- Has runway from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
- Is often truant from school, beginning age before 13 years.

c) Anxiety Disorders in Children:

Symptom	Presentations	Associated problems
Excessive autonomic activity	Somatic symptoms e.g. - palpitations, diarrohea, abdominal pain	School absences, iatrogenic problems, secondary gains.
Excessive psycho-physiological reactiveness	Startles easily; 'fight not flight'; 'cognitive shut down'.	Symptoms perceived as aggression or misbehavior
Phobic avoidance	Avoidant behaviour: opposition or panic when exposure forced	If overt, possible stigmatisation; alteration of self concept
Anticipatory anxiety	Worrying, nervousness	Susceptibility to panic
Panic attack	Palpitations, dyspnea, feelings of dread, chest pain etc.	Anticipatory anxiety; possible development of phobic avoidance
Sleep disturbance	Initial insomnia, nightmares, fear of dark	Fatigue, family conflict, day time sedation
Catastrophic undifferentiated anxiety	Panicky state plus cognitive shut down without evident precipitant	Generally limited to very young or to cases of pervasive developmental disorder or psychosis

d) Mood Disorders in children are manifested by feeling of sadness, sad appearance, crying, irritability, social withdrawal, anxiety, somatic complaints, sulkiness, conduct disorder/fighting, mood-congruent hallucinations.

e) Childhood Post-Traumatic Stress Disorder: The effects of trauma on children can be categorised into 4 groups:

- Visualised or otherwise repeatedly received memories.
- Repetitive behaviours
- Trauma-specific fears
- Changed attitudes about people, life and the future.

f) Scholastic backwardness results from the above problems in children residing in areas of conflict.

Intervention modalities for acute stress disorder and post-traumatic stress disorder

A. Treatment/Medication

Conceptual basis for medication

1. Medication can be used in an abreative context as a means to help uncover repressed or dissociated materials that give rise to a potentiality of damaging symptoms.
2. Medication helps the individual to restore his or her normal coping mechanism.
3. Pharmacotherapy aids the psychotherapeutic treatment during recovery process.

Biological Basis for Medication effects in Stress Disorders:

1. Kindling/Sensitization:

Repeated presentations of a subthreshold stimulus can sensitize limbic circuits, producing lower thresholds of firing. Analogously, repeated exposure to severely traumatic events may ultimately produce lowered threshold for experiencing intrusive symptoms. The benefit of carbamazepine for PTSD may provide support for this model. Related to the concept of kindling is that of sensitization, which states that exposure to a single or repeated stimulus may sensitize animals to further stresses of lower intensity.

2. Inescapable Shock/Learned Helplessness:

Medication for the brain alarm center, the locus coeruleus, a non adrenergically rich region of the brain stem. Drugs that have anti-adrenergic effects and that down- regulate the locus coeruleus prevent the development of learned helplessness in animals that have been exposed to inescapable shock, and likewise are effective in ameliorating the symptoms of PTSD in humans. Such drugs include the monoamine oxidase inhibitors (MAOIs) and the trycyclics anti depressants such as imipramine and amitaprine. Specific symptoms that reflect locus coeruleus overactivity include intrusive, autonomic and hyperarousal symptoms.

3. Secrotonergic mechanisms:

There is growing evidence that serotonin-5 hydroxytryptamine (5-HT) is important in PTSD. SSRI drugs such as fluoxetine (10 to 40 mg), are effective in strengthening impulse control and mood disturbance.

4. Benzodiazepines:

Alprazolam (1 to 6 mg per day) is a useful drug in PTSD.

5. Other Drugs:

Anticonvulsants such as Carbamazepine and Beta-Blockers are useful in PTSD. The alpha-2 against drug clonidine, which suppresses activity in the locus coeruleus is also useful in PTSD.

In summary, studies suggest that antidepressant drugs have therapeutic effects on PTSD that are significantly greater than non-specific effects emanating from placebo. Antidepressant drugs do reduce intrigue, avoidance and hyperarousal symptoms of PTSD.

B. Psycho- social interventions in acute stress disorder and PTSD

The agenda issues in professional psychotherapy are:

1. Dealing with distressing intrusive recollections.
2. Dealing with volatile emotions such as anger, irritability, sadness and despair.
3. Dealing with notions of guilt for behaviour during the event – acts of commission or omission.
4. Dealing with the losses sustained in the trauma.
5. Dealing with the strain that the dysfunctionality suffered by the unwell survivor causes for himself, his family and friends.
6. Dealing with the discomfort of constant increased arousal.
7. Dealing with the vast existential dilemmas raised by the event which requires reestablishment of cognitive schemata about the self and world, and the ability to foresee and plan for the future without guarantees (Fairbank & Nicholson 1987, Horowitz 1976)

Psychotherapy for Acute and Post-Traumatic Stress Disorders:

Principles of therapy
a) Timing
b) Trauma focus
c) Commonality
d) Community Orientation
e) Anticipatory guidance

Specific Treatment Modalities:

1. Critical Incident Debriefing: Where the working through process involves both cognitive and affective restructuring of the experience.
2. Mini Marathon sessions consist of 3 components
   - Sharing stories of the trauma
   - Sharing symptoms
   - Stories of survival and heroism
3. Front-line Combat therapy consists of 3 principles of treatment
   - Treatment should be close to the place of conflict
   - As soon as possible after the traumatic event
   - The expectation is towards early return to normal life.

Psychodynamic Interventions: The use of dynamic psychotherapy groups are useful interventions for trauma survivors although such interventions have scarcely been investigated.

4. The Hypnosis: Hypnosis is employed for treatment of trauma related symptoms. The rationale for the use of this technique involves the spontaneous occurrence of dissociative symptoms after the psychological trauma.
5. Cognitive Behavior Therapy: Cognitive theory is based on the contention that the behaviour is secondary to the way in which persons think about themselves and their roles in the world. Maladaptive behaviour is secondary to ingrained and stereotyped thought, which can lead to cognitive distortions or errors in thinking. The therapy is aimed at correcting their cognitive distortions and self-defeating behaviours. The cognitive model of depression includes the cognitive trial, which is a description of thought distortion that occurs when a person is depressed. The trial includes:
   - A negative view of self
   - A negative interpretation of present and past experience
   - Negative expectation of the future.

Cognitive restructuring involves 3 steps

The first step is educating patient about the cognitive model and that the underlying cognition is a major determinant of emotional responding.

The second step in cognitive restructuring is monitoring and analyzing dysfunctional thoughts. For example some key questions for challenging negative automatic thoughts could be:

- Is there an alternative explanation?
- What is the evidence that this thought is true?
- What is the effect of continuing to think this way?
- What is the best outcome, worst outcome and most realistic outcome?
- What is the likelihood that this will happen?

The third step in cognitive restructuring is to challenge and change cognitive distortions. Example of negative thoughts and rational response would be:

Negative thought	Rational response
I have no control over this situation	It's true that I can't change what happened, but I can control how respond
I can't return to my old job, I am worthless	Even though I am not able to do the same kind of work, there are a number of other jobs that I may be able to do.
It's not fair that I am being treated this way.	Life is not always fair, sometimes things go my way, other times they don't.
I am burden on my family.	My family has had to give me more support lately, but I do a lot of things for them as well.
No one really cares about me.	There are people in my life (e.g. spouse or child) that I can turn to for support and love.

6. Cognitive Behavioral Group therapy: Cognitive behavioural group therapy for a group of trauma victims can also be conducted using the above principles.
7. Exposure Treatment: One set of cognitive behaviour approaches employed with PTSD patients is exposure treatment in which patients confront feared situation. Exposure to repeatedly reliving the trauma with the act of facilitating the processing of the trauma helps in the treatment.
8. Anxiety Management Training: Another approach is anxiety management training when the anxiety is all pervading in patients daily functioning. This is done by teaching patients steps to reduce anxiety e.g.- Benson's relaxation, biofeedback, Jacobson's relaxation etc.
9. Systematic Desensitisation: Successful outcomes with systematic desensitisation in which patients are exposed to fearful imagery when in a relaxed state have shown beneficial results.
10. Eye Movement Desensitization and Reprocessing (EMDR): This is a new technique called Eye Movement Desensitization and Reprocessing. The technique involves the patient imagining a scene from the trauma, focussing on the accompanying cognition and arousal, and tracking the therapists rapidly moving finger. The sequence is repeated until anxiety decreases, at which point the patient is instructed to generate a positive thought and to associate with the scene while moving his/her eyes.
11. Stress Inoculation Training is another program for victims of violence or trauma. This is a two- stage treatment. In the first stage called the educational phase, the treatment program rationale and theoretical basis of the stress treatment is explained. The second phase of SIT is focussed on the acquisition and application of coping skills and includes training in deep muscle relaxation, breathing control, role-playing, covert modeling, thought stopping and guided self dialogue.

In conclusion it can be stated that in Acute Stress Disorder and PTSD symptom severity, degree of exposure to trauma, unstable personality, autonomous instability and presence of co-morbid depression all serve as predictors of poor response to single treatment interventions. Multiple interventions such as medical and psychotherapeutic interventions would be called for.

MENTAL HEALTH PROGRAMME IN J&K

Dr Sibyl Jade Pena, Medical Doctor
Dr Sue Gibbons, Clinical Psychologist
Medicins Sans Frontieres

Medicins Sans Frontieres (MSF) is a voluntary Medical/Humanitarian Organization. Working in over 80 countries worldwide, the organization offers assistance to population in distress, to victims of natural or man-made disasters and to victims of armed conflicts, without discrimination and irrespective of race, religion, creed or political affiliation. Our guiding principles are neutrality, impartiality and independence.

This, for example, can imply that we are working on both sides of a conflict addressing the needs of the defenseless victims, the population, of the conflict. In recognition of MSF'S work, we received the Indira Gandhi Peace Award in 1996 and the Nobel Peace in 1999.

MSF started to work in the field of mental health in the early nineties. The main reason was that we found many people suffering from psychological problems in our clinics and hospitals in the project we were working. The patient would present themselves with for example stomach complaints, headaches and general fatigue. However after clinical examination, no real physical problem were found.

During the War in Bosnia, MSF set up a system for mental health, together with professional health staff, psychologist and social workers. In Indonesia and Sri Lanka, a mental health programme was started by MSF for the people suffering from Post Traumatic Stress Disorder.

During our visits in Kashmir in mid-2000, many people indicated that psychological problems as a consequence of tension are increasing, both at individual as well as community levels. Doctors have been seeing an increase in psychosomatic disorders; patients were going from one doctor to another with vague complaints and no relief despite various prescriptions. Psychiatrists are overwhelmed by the sheer numbers of patients presenting at the government hospitals and their private practices for psychiatric problems.

MSF training activities in Kashmir started in fall/winter 2000 with initial sensitisation training of some doctors. In addition, discussions were held with various members of the medical community, the villagers and the mental health professionals in Kashmir. Since May 2001, we have started a pilot program in Ganderbal block together with the Government Medical College and the State Ministry of Health.

A. Grass roots level

1. Sensitisation training of PHC doctors – Various 2 days training for medical doctors were held especially for those doctors working in the peripheral health facilities (PHC's and CHC's). The aim was to create and increase awareness on the consequences and

symptoms of stress and trauma related issues. Also basic counselling skills were taught. In total 40 Doctors attended the training.

2. Training of paramedics – In addition to the doctors, a selected and limited number of paramedics were also trained. MSF provides ongoing technical training on the job and clinical supervision to the paramedics.

The first phase of training process started with awareness training for all paramedical staff of the selected health facilities in the Ganderal block.

In the second phase, the training continued with the selected number of paramedical staff (20) who would start working as psychosocial workers in the communities. Further training was given in:

- Identification/referral of those suffering from psychosocial complaints,
- Awareness/education of stress related issues, promotion of self help
- Strengthening of individual/community coping mechanisms.

Paramedics are selected for these activities because they are working in the community. The community approach was adopted to strengthen community coping mechanisms, as this is more appropriate to the Kashmir culture than the individual counselling, which is more a western model. Also this approach is more preventive.

Of the 20 paramedics who attended the training, 8 were selected to become paracounsellors. At least one full time counsellor per health facility will receive additional training of counselling skills. Initially, they will work 1–2 days, then as the work picks up, we hope to increase the time. They continue to have client contact as nurses etc. and if they are purely counsellors at this stage, people may not want to talk with them as the concept is still quite new among the community.

The health workers who are trained as psycho-social workers will:

- Raise awareness on trauma and stress-related issues,
- Carry out needs-assessments (door-to-door survey)
- Conduct group discussion on these issues
- Detect and identify patients who might be in need of counselling
- Refer patient to the counsellor
- Implement community activities.

The health workers who are trained as psycho-social workers will:

- Carry out individual counselling processes and group-wise counselling
- Provide psycho-education
- Refer patient to other specialists
- Link up with the psychiatric facilities in Srinagar
- Educate their colleagues and act as a consultant for stress related problems.

I must say that training participants were all enthusiastic- some trainees told families about what they learned and tried the breathing and relaxation exercises with them. It's like a problem that was there all along and now they have a name for it, that it is out in the open, and they could discuss it in the community. Learning that there are other ways to deal with psychosocial problem is also something new for them and slowly they see that it works, without resorting to pills.

3. Establishment of counselling services and community awareness activities – The services are new to both the health system and the community. For the newly trained health workers, counselling is a difficult and demanding job. Feedback and support are needed for them to carry out the activities. On-the-job training and clinical supervision will be done by the MSF-psychologist on weekly basis. During visits to the health facilities, the MSF-psychologist will facilitate discussion on cases and problems faced by the trained health workers. In addition support in organizing community awareness activities on stress-related issues will be provided.

Early analysis of evaluation from the training showed very positive feedback. For example:

Feedback given by the participants

Parts of the training I found useful were:

- All, particularly the practicals and group discussion
- Children psychology, listening skills, knowledge about suicide
- Respect of clients
- The required skills of counselling, having patience, tolerance and expression

Because:

- In role plays it was easy to know how the client and counsellor must be feeling like and how they should behave
- Counselling helped me personally a lot. Previously I did not have those qualities in me, but now, hope that I can give a lot of confidence to the clients.
- I learnt about all the symptoms in the training. I did not know earlier that these things were associated with stress.

B. Referral level

Community-based programs need link-up with referral network of doctors and tertiary facilities as serious psychosocial problems need specialized care. Thus, MSF is also conducting activities in the psychiatric hospital in support of the rehabilitation of patients.

1. **Rehabilitation activities for patients through working with nurses, occupational therapist and other staff –** This is to enable the staff to carry out recreational & rehabilitation activities with the patients.

It will:

- Reduce boredom, which may precipitate depression, frustration culminating in aggression etc.
- Occupy patients in meaningful activities to increase their sense of self worth.
- Facilitate positive interaction between staff & patients.
- Allow patients to develop skills, which may enable them to gain employment at a later stage.

We asked the staff to carry out a small survey with the patients, asking them which activities they would like to participate in. This showed the patients as well as the staff, that we wanted to include patients in our decision making and provide them with activities that they chose. It also facilitated some staff-patient contact as well as guiding our thinking about what the patients would like to do. To date we have received 30 responses to the questionnaires. Patients stated that they mostly do nothing during the days they sit or lie on their beds, they cry and feel sad. They requested to do things like sewing and knitting, carpentry, dancing and painting, football and volleyball, gardening, music and singing. Many stated that they wanted to go home, too.

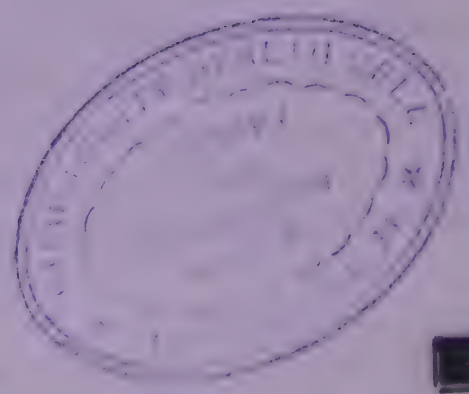
The nurses, wardens and the orderlies have started playing football, badminton & volleyball with the patients as a result of our meetings, using the equipment we have provided. We have also bought drums, tambourines and harmonica and the patients and the staff have been singing, playing and dancing. This has obviously made a difference to their lives. A warden told us that one patient had not spoken since he arrived at the hospital until they started a singing group. Also, following our interventions, the Head of the Department used hospital funds to buy a stereo system for the patients.

Two teaching sessions were done by MSF with the staff, one on handling aggression and other on stress related problem in the community. Also discussions were held on working at the hospital, the types of difficulties patients experience, how they handle it etc.

2. **Supervision of an anxiety management group for in-patients and out-patients –** Two professionals (a psychiatrist and psychologist) run a weekly anxiety management group, which is open to in & out patients. Participants are taught simple strategies to control and reduce their anxieties. The two attend 2- weekly supervision sessions with the MSF mental heath trainer. Eventually these two will train other staff to run the group. This is good use of time as they can teach simple principles and strategies to 8 people at once and the participants can support each other in coping with anxiety and learn that others are going through something similar problems.

3. **Facilitation of an intervision group for doctors and psychologist working at the government hospital for psychiatric diseases** – Once a month, the psychiatrists & the psychologist meet for two hours with the MSF mental health trainer. Confidential discussions of work with clients are done for support and to learn from each other. This is also to ensure appropriate and good quality patient care. The sessions provide an opportunity for everyone to develop ideas for future interventions.

Over the years, Medicins Sans Frontieres has been involved in as we call it "mental health programmes" in many countries in different continents. We realise that each country and its people have their unique problems and coping mechanisms. We also realise that we are very new here in your country and have to learn a lot about your health systems and approaches addressing psychological problems.



12062
MH 102 Dog

PSYCHOLOGICAL INTERVENTION IN POLITICALLY VIOLENT CONTEXTS: KASHMIR

Shobna Sonpar, Ph.D.
Clinical Psychologist

The following account is drawn from my experiences of working in the Kashmir valley in the past year. Although my involvement in Kashmir is fairly recent, it has been intensive and emotionally quite intense. While I expected it to be professionally challenging, I was not anticipating it to be so personally challenging to my beliefs and to my assumptions about an existing moral order, nor that it would be the impetus of my sociopolitical awakening. It would be fair to say that my continuing professional involvement comes from the personal meaning of this work for me. I undertook to do this work in my capacity as a mental health professional and it has ranged from doing a preliminary psychological needs assessment survey to conducting basic level training programs in counselling skills for lay people and for doctors, to a capacity-building exercise among university students, to making a brief group therapy intervention. These programs have been sponsored by different NGOs at different times. Being a practising clinical psychologist and therapist by profession, this is the knowledge base that has informed my work.

In the account that follows, I first discuss some general issues before going on to describe a couple of specific programs, and end with a few observations about mental health interventions in particular.

For any community intervention program, the manner of its entry into and its acceptance by the community, are often the aspects that determine its ultimate success or failure. In the context of political conflict, this issue is further confounded if the intervention is by an outsider, and even more so if one is perceived to be from the 'enemy' camp or affiliated with those perceived to be enemies. In such situations, any intervention is construed as a political act in that it is thought to have motives beyond those stated, and is believed to have the potential to affect the power balance among various groups. It is therefore not enough to go in with good intentions and attempt to address the mental health needs of the community because one may find oneself floundering at the outset if one is not aware of the political dimensions of one's entry. In the programs with which I was involved, these issues invariably surfaced and needed to be addressed if the work was to proceed. Commonly raised questions were 'why are you doing this, who has sent you, what is there in it for you, do you really care, are you sincere about what you say.' Given the context of pervasive distrust, especially of outsiders, these issues were laid to rest, if at all, over a considerable period of time during which my credibility and sincerity were repeatedly questioned. For instance, in the course of my work in Kashmir, one community volunteer expressed an apprehension as to whether counselling was something like 'brainwashing' where a person's mind might be changed against his or her will. Newspapers have made derogatory reference to people escaping the heat of the plains on the pretext of holding trauma counselling workshops in Srinagar. Others have said that such programs are irrelevant since they are culturally alien and since the mental health needs of Kashmiri

society are being met by traditional spiritual practices. It is therefore to be expected that such programs will be viewed with suspicion and even hostility at least initially.

A second issue that has to be taken into account when one is seen to be an outsider, is that one will tend to be told a certain kind of story. This story may not be false, but it may not be the whole story. For instance, in a three-day workshop with students of Kashmir University considerable time and energy was spent on the detailing of the oppression, injustice and danger they had to endure. This group of students continued to meet regularly after the workshop, and it was reported that there was a complete change in the issues that came up for discussion when they were by themselves. Left to themselves, the issues that concerned them the most were the mundane ones of unemployment, studies, romance, responding to perceived harshness of university discipline and so on.

A third issue that confronts the mental health professional is the multiplicity of needs, pressures and tensions that people under such circumstances have. The fact is that therapeutic help is only one among many kinds of help needed, such as financial, legal, medical, educational, administrative, occupational. Often a person's perception of his or her problem and the assistance needed may differ from that of the mental health professional whose focus may be only on the psychological dimension. Even when he or she is evidently psychologically traumatised, such a focus may seem meaningless to the person. It then becomes important to find ways of meeting present needs while opening up a therapeutic space that may be used later. Difficulties arise when the mental health professional is called upon to meet needs that are outside his or her professional capacity or when he or she is treated as a door-opener for getting financial, legal or some other form of assistance. Such a situation frequently arises where helpers are few and the stresses and needs so many. Ideally, it should be possible to point a person in the right direction so that he or she gets to the appropriate helper. But this is easier said than done where the welfare system is under-resourced and badly managed, if not always corrupt. This kind of situation creates dilemmas for the mental health professional since it raises questions about the therapeutic convention that distinguishes between what legitimately falls within the province of therapy and what does not.

A fourth and more fundamental issue with regard to mental health in a context of long-standing political violence is the danger of reducing social, political, economic, human and moral problems to a health problem. On one hand, medicalisation of the problem probably enables those affected to seek relief, and may indeed be helpful especially when drug treatment and psychological help are both available. On the other, medical models may be too narrow to do justice to the full extent of the horror and brutality that marks such political violence, nor to the moral and existential questions raised. Thus although the South African Truth and Reconciliation Commission recognised the psychological needs of the survivors who testified by providing them with psychotherapeutic support, it was also clear that the social process of reconciliation was not about treating psychopathology.

It is customary to use the conceptual framework of trauma when discussing the mental health needs of those living under violent conditions and while it may be too narrow and

health-focused to be all-encompassing, it is a useful framework nevertheless. What I also found in Kashmir was that not only are there very many traumatised individuals, but also that there is a collective trauma that the society has suffered. This has obvious implications for healing since it makes for a context where the normal community supports that facilitate recovery are themselves damaged. These may range from the normal social support of kin, neighbours and fellow-workers to the availability and accessibility of resources for education, employment, healthcare and so on. The emotional life of the community has also been deeply affected in that it is dominated by pervasive fear, distrust, a deep sense of loss, withdrawal and isolation, anger and cynicism as well as hopelessness, powerlessness and despair. The mental health worker thus may have to look at working therapeutically with individuals in a context of ongoing and collective trauma, as well as to consider ways of restoring community health (Sonpar, 2000a). The twelve years of political conflict have also led to many social changes and people are also responding to these transitions.

A broad framework that I have found useful in understanding and reaching out to people as well as when imparting training to lay helpers is around the distrust, disconnection, disempowerment, despair and the destruction of meaning that characterise the experience of trauma. The objectives of intervention thus become the building of trust, the restoring or forging of bonds, the regaining of a sense of control, agency and efficacy in the face of helplessness and hopelessness, and the search for a meaning that would help make sense of what has happened as well as restore a sense of some moral order. These objectives could as well apply to individuals as to communities. Thus victims become survivors, and may even thrive.

In working towards these objectives, it is worth emphasising that the core of good therapy practice anywhere also applies here. When working with individuals who have gone through terrible situations, it is possible to forget this in one's own anxiety to fix them fast. Simply put, people need to be heard, they need to feel safe, they need to express their feelings, they need to have their boundaries respected and not be pushed. The most important of these is perhaps the need to establish a physically and emotionally safe and trustworthy relationship and environment. People who have suffered psychological trauma may also have some more specific needs. They may need help with processing their traumatic memories and with learning to handle extreme emotional states without numbing or dissociation. While being alert to these aspects, it is important not to focus narrowly on the traumatic experience to the exclusion of all else that may be troubling the person. Also one needs to be alert to what aspects the person has found to be most difficult, rather than foisting one's belief about how trauma affects people.

The following discussion about my experiences working with a group of women therapeutically and with a group of students brings up some additional points.

Women who have suffered the disappearance of a family member, commonly a husband or a son, experience a high degree of distress. The Association of Parents of Disappeared Persons (APDP) is an organisation of such persons in Kashmir. Some of these women participated in a two-day long group sponsored by OXFAM to talk about their lives and

their problems (Sonpar, 2000b). All these women had some symptoms of psychological distress, commonly a mix of anxiety and depression. Without certainty of the death of the missing person, without being able to view the body, without being able to have the customary rituals, their loss could not be completely mourned. Hope that the person would somehow be restored to them was double-edged in that it fuelled their continued quest for the missing person, but in so doing, it did not allow for psychological closure to take place. Indeed for those for whom the quest had become a mission, accepting that the person was in all probability dead, felt like a betrayal. The pain of the loss and the anger at the injustice were therefore both very alive even among those women whose kin had disappeared many years previously. These women also had many other problems. Financial difficulties and the responsibility for their children's welfare weighed heavily on them. The uncertain social position of those whose husbands were missing, referred to as the 'half-widows', made them vulnerable to gossip on one hand, while denying them the relief to which widows were entitled and the possibility of remarriage.

It was anticipated that there might be some difficulty in working in the conventional psychotherapeutic mode which is predominantly verbal and which depends heavily on the capacity for finely-nuanced psychological introspection. This was made even more difficult because the women were largely Kashmiri-speaking and an interpreter had to be used. Further, since the workshop was only for two days, the goals were modest.

In the group each woman shared her story, how her life had been before and after the disappearance, her memories of the missing person, her emotional and social supports, her grief and her anxieties, and her vision of the future. Focus was particularly directed on her strengths and resourcefulness. This sharing was emotionally cathartic and each woman derived much comfort from the warmth and support she received. The therapeutic dilemma lay in helping these women to move beyond their grief and anger, to hope and plan for a future that had joy while still remaining loyal to the one who had been lost to them, and to be able to do so without having any certainty of the death of the lost one. Clearly, their pain and anger had to be acknowledged while honouring their loyalty and devotion to the lost loved one. It had to be remembered that these women were also bearing witness in the fact of their being in pain and in their not letting their lives become 'normal'.

Hence it was decided to use a simple graphic method to portray each woman's life. This consisted of a time-line diagram – a line representing the life of a woman, with important events and transitions, happy and sad, marked on it, and also projected into the future. This exercise was useful in a number of ways. First, it enabled a 'defocusing' on the particular traumatic event of disappearance and helped to place it within the flow of a life story in which there was a past and could be a future. One fact that emerged very sharply was that the lives of these women were replete with tragic events of which the disappearance of the family member was perhaps the most recent. Untimely deaths, illnesses, in-law problems and financial crises were common. All the women spoke of having seen only sorrow in their lives after getting married in their early teens (*humne zindagi mein dukh hi dukh dekha hai*). They agreed that the grief they now felt seemed as if all the accumulated pain had come together. They accepted a formulation of their lives as having come to a standstill after the disappearance, and also as if the disappearance

had cast a dark shadow on their future, a shadow that kept out all light and colour. Extending the metaphor around stuckness, darkness, light and colour, each woman was encouraged to choose colours with which she wanted to represent her future on the drawing. They all chose bright and cheerful colours and gave their reasons. This act seemed to get around an impasse in the group work – namely their verbal insistence on the inevitability of staying unhappy forever and refusal to envision anything different. Following this exercise there was a distinct lightening of the mood in the group. It is conjectured that this act symbolically gave them permission to move on, to entertain the possibility of happiness without feeling disloyal or incurring the disapproval of others. Cultural factors seemed relevant here in terms of how mourners, especially women, are expected to be. At the end of the workshop, one 60 year old woman repeated several times with a naughty giggle that if only her husband were to see her now lounging in a *shikara*, he would be furious. For her it did not seem relevant that her husband had divorced her more than 40 years previously and that she had nothing to do with him since. What was significant was her pleasure at thumbing her nose at the grim weight that traditional social propriety imposed on women like her.

Cultural sensitivity and respect is obviously an essential part of working with groups like these. For instance, the dominant socially-approved narrative of coping was one that emphasised fortitude (*sabar karna*), and prayer. It was important for the group that the virtue and dignity of this be honoured before the women could speak of other more individual ways of coping. Similarly, the intervention that the participants believed to be most helpful to someone in emotional distress was to remind him or her that there were others who had suffered worse experiences. It was thought that this would help the person regain a sense of perspective and thus contain the expression of unbridled and self-indulgent emotion. This is in keeping with a cultural code that is sociocentric and where shame is a powerful method of social control. Traditional psychotherapeutic conventions that encourage the expression of feeling would obviously be at odds with this, at least in the beginning. Peeling away the layer of pressure for, and internalisation of, socially appropriate behaviour is a necessary first step before the underlying layers of a woman's deeper feelings and conflicts can emerge. For instance, it was only towards the end of the workshop that one woman began to talk hesitantly about the tensions in her marriage after her son went missing.

The experience with students was in the context of a capacity-building exercise sponsored by the South Asia Forum for Human Rights (SAFHR). Stemming from the recognition that twelve years of political violence had led to considerable cynicism and demoralisation of the student body, a three-day workshop was held that aimed to address the blocks to enthusiasm and initiative (Sonpar, 2001). The students were all post-graduate students of Kashmir University from various departments and the workshop was conducted with the help of a facilitator from the NGO, *Samvada*. Much of the proceedings were dominated by their description of the oppressive and dangerous conditions of their existence, the need for a 'political solution', and their belief that they were helpless to take any proactive steps under such dire circumstances. A dynamic that emerged very clearly in the group, and which operates to a greater or lesser extent in many sections of the society, was the perceived opposition between 'relief' related work such as counselling and the 'struggle'. It was felt that such relief work, by soothing symbolic wounds, might weaken the 'struggle'

when it was important to wear these wounds as badges of oppression and atrocity and as goads to action. To illustrate from another workshop with community volunteers, one man described his experience of doing a guided imagery exercise where the group had to journey to their chosen 'safe place'. He imagined embarking on this journey whilst fleeing from fire behind him and around him. As he proceeded he found there was fire in front of him too. He concluded that he could not and indeed did not want to find a safe space.

In the student workshop, anger was also expressed that outsiders, particularly those perceived to be affiliated to the oppressors, should venture to offer a balm when they had inflicted the wounds. It was important not to get drawn into these arguments while acknowledging the hurt and the anger. To shift the discussion along a more fruitful path required some persistence and ingenuity. One participant said with some irritation that it was useless to talk about perspectives and possibilities because a caged bird can see only the bars of its cage whatever be the vantage point it is perched upon. While not denying this, a parallel was drawn as to how there can also be cages of the mind and that sometimes these mental cages prevent one from noticing the windows that may be open. An engaging and fruitful exercise that followed up this theme and broadened it further was to have the group draw on a long banner the major events that had occurred in Kashmiri history and to discuss how these may have shaped contemporary psychological and sociocultural conditions. In order to do so they had to agree upon which events to include. One powerful process that resulted was that it made them engage in dialogue with one another despite their sociopolitical differences. This was no mean achievement given the fact that there is bitter distrust among various groups and that dialogue has been practically nonexistent. Also by lengthening and broadening the historical frame, the participants had to grapple with the possibility that there may be multiple perspectives instead of one 'correct' history. A further broadening was encouraged by having the students look at their personal and collective history through other social categories of class, caste, gender and age.

The most encouraging outcome of the workshop was the desire of the participants to keep the dialogue going on. With this purpose in mind, they formed themselves into a group, gave themselves a name and have been meeting regularly to discuss issues that concern them. Several of them also participated actively in a week-long peace education seminar. Two concrete steps they have been taken are to procure documentary videos to discuss social issues, and to organise exposure to the work of active NGOs in the rest of the country. This would be a useful capacity-building exercise in that while the students are eager to contribute socially, they lack the knowledge and resources to go about it in an effective and meaningful way.'

The above illustrates the role that mental health professionals can play outside their traditional clinical domain. In fact, both at the level of understanding the group processes in the larger society, as well as in terms of designing and implementing interventions that might be useful, insights from social and clinical psychology may be valuable. One area that immediately comes to mind is the cycle of violence whereby violence begets violence due to the formation of meaning systems that are developed around hate and revenge and which lead to further group polarisation. There are several lessons and skills derived

from therapeutic work with individuals that may be extrapolated to inter-group hostility and indeed are central to inter-group conflict resolution. To name a few - the attitude and skills that go into active listening and empathic understanding, the recognition of the process of projection onto others, the importance of reducing polarisation and the tendency to black-white thinking by contextualising events and preventing oversimplification of narratives, the separation of the facts about events from the attribution of intent, the prevention of overgeneralisation from single incidents, the exploration of fears that lie behind postures of hate, and the vulnerabilities that are masked by postures of strength, and so on.

Another area concerns the healing of collective trauma and the need to have a constructive engagement with the difficulties of the past. As Desmond Tutu has said when talking about the South African Truth and Reconciliation Commission, 'the past has a way of coming back to haunt...it does not go and lie down quietly'. The Commission explicitly set out to be a healing process for that society's collective trauma. The methods it used are familiar to therapists – of creating a space where survivors can feel safe and be heard, of breaking the silence, of giving voice to emotions, of facilitating cognitive recovery by creating an accurate picture of the past, of absolving victims from feelings of guilt and personal causal responsibility, of addressing issues of restitution and forgiveness, of a process where not only victims but also perpetrators come to terms with their past (Hamber, 1995).

I would like to conclude with some broad practical observations regarding mental health interventions in contexts of political violence. First, group work is of great usefulness in such situations. Not only does it have therapeutic value in the sharing and the mutual support it provides, it is practical in view of the numbers involved and the limited resources available. It also enables the building of trust and the facilitation of dialogue. The more intense the group work, the greater the likelihood of encountering one another as persons so that differences of culture, class, religion and politics become unimportant. This is the basis of the group-work that Carl Rogers, whose counselling theory underlies much contemporary counselling practice, initiated and which has been successfully used in the context of race relations and ethnic strife (Rogers, 1999).

Secondly, since violence and trauma characterise life in such conflict areas, it may be useful to be acquainted with specialised forms of trauma intervention such as critical incident debriefing or eye movement desensitisation and reprocessing (EMDR). For instance, in a recent application of EMDR to populations affected by the earthquake disaster in Gujarat, it is reported that large numbers could be treated with highly positive outcomes (Mehrotra, 2001). These techniques have the advantage of being brief and independent research has confirmed their beneficial effects. These methods help those affected to process their traumatic experiences by having them experience the memories in a way that distances them from the original experience. It is also hypothesised that these methods work because they address the biophysiological base of traumatic memories and nudge these to move into normal autobiographical memory. As with all techniques, it is important to be alert to the danger of applying them in a mechanical way while not paying sufficient heed to the therapeutic relationship, and to the readiness and specific needs of the person being helped.

Thirdly, disseminating relevant knowledge and skills would be an essential component of a mental health professional's role in such a context. This would include psycho-education for the general public through the mass media and outreach programs. These could help people to normalise their experiences, offer self-help advice as well as inform them as to when they should seek professional help. This role may also involve training lay volunteers in basic counselling helping skills. My experience of conducting such training programs points to the necessity of having a modular approach to the training over the space of 9–12 months, in the course of which the trainees have intensive supervised practice. One-off training programs engender a lot of hope and enthusiasm initially. But in the absence of practical clinical supervision, the trainees flounder and become disheartened. A second point worth mentioning is that most volunteers are likely to have had some brush with violence personally. Hence doing personal work with them as part of the training is important.

Finally, it is well-established that burn-out is a significant risk factor for mental health workers and others who work in such areas of conflict. There is need therefore for workers in these contexts to have sufficient professional and personal support and consultation.

References

1. Hamber, B (1995). Dealing with the past and the psychology of reconciliation. Public address presented at the 4th International Symposium on the Contributions of Psychology to Peace, Cape Town, 27 June 1995.
2. Mehrotra, S (2001). Report on the use of EMDR with Gujarat earthquake survivors. Unpublished. Dept of Psychology, SNDT Women's University, Mumbai.
3. Rogers,C (1999). On personal power. Srishti Publishers, New Delhi.
4. Sonpar,S (2000a). Kashmir: trauma and psychological intervention. Report submitted to the South Asia Forum for Human Rights, Kathmandu. In Psychological Foundations – The Journal, Vol II (2), 84–88.
5. Sonpar,S (2000b). Report on trauma counseling related workshops. Unpublished, OXFAM, New Delhi.
6. Sonpar,S (2001). Report on Kashmir University students' workshop. Unpublished, South Asia Forum for Human Rights, Kathmandu.

LIVING AGAIN: SURVIVING POLITICAL VIOLENCE

Ms Arvinder J.Singh
Consultant-Trainer; Counsellor

I am going to present this paper around the key themes that I have been keeping at the back of my mind in working with people impacted by trauma.

My work began with people in Punjab & Srinagar with RGF and has now expanded to working in Gujarat (with Action Aid), and Assam & Manipur (with North East Network). As I spent time with the people I learnt more & more about the community, I felt the need for locating support structures and counsellors within the community in order to be able to do any meaningful intervention.

I also felt that with my limited understanding and perception of various cultures and for any meaningful social change, it is important to empower the community by its own human resources, based on the theory that people from within the community would be more effective in 'recreating' lives as they would have a rapport with the members and a deep understanding of the cultures in which they live and would be working. Thus started the process of training people who have been working in the community, not necessarily as counsellors, but have the commitment and personal human qualities to carry on the work.

My work with the communities has been at two levels – one at the level of running support groups and other at locating local people who have experience of working with communities and training them in basic counselling skills and running support groups. The training is phased out starting with focus on basic counselling skills moving on to dealing with trauma and running support groups. Follow up workshops are organised where the newly trained para-counsellors get a chance to discuss cases, problem areas and identify further training needs. These trained para-counsellors are being supported for a period of two years during which training and supervision of their work is carried out at regular intervals. By the end of these two years it is hoped that these groups of para counsellors would be able to support themselves.

These trained people worked in the community and evolved in their work. In Srinagar, for instance, an NGO network group has emerged as a result of the trainings. This network group calls itself CARE Srinagar which runs support groups and creates awareness, which Mr Rasheed & Ms Sofiya would talk about today.

As they were chosen from the community, I felt they had also been impacted by trauma (violence) in some way. Therefore helping them deal with and share their own situation would help them heal themselves, come together and work together as a group. Thus training included not just skill building but also dealing with their own situation. This helped them emerge as stronger people who could identify their own strengths, tap their resilience and find new identity. This experiential method of training helped them to learn skills, and also contextualise these within their own community settings.

In an effort to be able to provide therapeutic interventions and to recreate their lives, support groups were conducted and the social workers/counsellors were also trained in running these support groups to help people 'restory' their lives and therefore heal. The support groups have also served as a platform for people to 'be themselves', feel accepted and are permitted to be "normal" by getting them to share, cry, laugh and have fun in a safe environment. Ms Shabnam from Batala who has been conducting such groups will talk more about it.

It has personally been very important for me to demystify the concept of counselling and trauma counselling as it has also helped in dealing with the stigma attached to it. When people from within the community are trained, they go through some sort of healing process themselves, and are able to treat counselling as a healthy intervention.

With this backdrop, I now get to the key themes I have been working with:

Violence

In situations of political violence people are impacted not just by the devastating event but also during the phases before and after the actual event. In situations of political turbulence, even before the devastating event, people often become aware of the impending danger and live in a period of anxiety and anticipation. This can be acutely traumatic as the uncertainty of the future is coupled with fear about safety. The phase of adjustment after the devastating event has its own set of disappointments, conflicts, fears as well as maltreatments, sometimes amounting to an even larger trauma than the actual act of violence.

Violence impacts us at a range of levels:

i) A level not just in terms of the devastating event, but also changing circumstances. When I worked in Punjab, a woman once told me *"I wish I didn't have these children to look after, I would not have to face this pain and humiliation of being a widow. I wish I could die ...."*

ii) The level of helpers, do gooders or therapists with the best of intentions may actually have their own personal agendas. They may tend to fix people in particular positions and may in the process block the opportunity for the clients to develop. If therapists view their clients only as victims their likely to position themselves as rescuers. Thus locking in an unhelpful pattern with very little possibility of change.

iii) Sometimes people impacted by violence tend to perceive themselves as victims and stay in that position thus denying themselves any resilience.

iv) When going through a traumatic situation people tend to develop a simplistic view of things – it's either good or bad, black or white and look for simple solutions. In Srinagar I came across a general feeling of distrust of people against the armed forces. People tended to see all army men as ruthless, cruel, heartless people and branded them as

their enemies. What takes away from us is staying within ideological themes which instead of empowering us actually disempowers and gives control to destructive forces.

Resilience

Resilience is paramount in rehabilitation. Resilience is the ability to withstand and rebound from crisis and adversity. In my recent visit to Gujarat I came across a village - Navagaon, where the entire village had turned to rubble due to the earthquake. The whole village came together and supported each other as one big family till relief came from outside. The food would be cooked for about 1500 people together in a make shift community kitchen. The men would bring water from distances and ensure that everybody got food and water. This bonding and coming together helped people in drawing strength from each other and tap their inner resilience.

The main ingredient in resilience is an individual's own resourcefulness, fortitude or character armor. Resilience is about building support systems and it is not just the inner strength but also strength derived from family, and other surrogate relationships – teachers, mentors or counsellors. The fact that the people we work with are in front of us still seeking assistance after all the adversity, testify to the fact that they are resilient. The therapists by viewing clients as resilient people help them restore their own. In a group therapy session with the group workers from north-east, one of the workers remarked.

"*I do not feel so helpless and victimised now, though I have gone through a lot. I think it has also helped me emerge as a different person. I never realised before, I have actually come a long way.*"

Resilience can also be developed by recruiting people from the community to look after the survivors. This helps in recreating the bonding that a family set up can provide and also plays an important role in rehabilitating and strengthening the bonds with the local community.

Home and containment

Home has a most important containing function as it provides a certain framework, boundary and a secure base for all its members. During political violence when homes and communities are destroyed people experience the lack of this containing function in a most acute way. This creates an immense sense of insecurity and a complete sense of disruption of the secure base to all those affected. When counsellors are working under such difficult conditions it is important that they should endeavour to reconstruct the containing function not only in terms of a physical environment but also in terms of their work by providing consistency and acceptance. Their reliability, dependability and regularity can offer clients the sense of security and thus enable the reconstruction of the containing function. The therapist in essence is also a container of people's anxieties, despair, loneliness and feelings of insecurity, anger etc.

In damaged communities it is important for the therapists to be sensitive to the concept of 'Home' – and adequate care should be taken to provide for anything that makes survivors feel 'at home'. Taking care of basic needs and necessities may help in improving the mental health status of survivors. However care should be taken in not getting trapped in recreating home by trying to provide for and trying to recreate similar situations for them which existed before the 'Devastating event'. It is important for the therapists to understand the underlying need for bonding and contain this need- it is this need for containment that the survivors seek.

Therapists should not forget to count in the tangible nature of their own therapeutic presence. The very way in which they bond with their clients can create a sense of being at home which may be more powerful and effective than a great deal of external attempts to make the clients life comfortable.

Identity

An individual's identity is an amalgam of individual as well as collective or cultural identity. So a person's identity is tied up with the group as well as self-image.

Survivors of political violence lose much more than their personal material possession and human relationships. As victims of collective violence they lose another aspect of their identity – 'Faith in Humanity'. When a neighbour attacks a neighbour and kills members of his family or when a person is singled out on the basis of belonging to a community, the victim not only loses a neighbour but he also loses faith in humanity. Without it a person no longer trusts that human values such as friendship, loyalty, love can exist and this has far reaching implications because it affects the very core of the identity of the individual.

During the, 84 riots, the sense of loss of identity was experienced by many Sikhs who had to remove their turbans and shorn their heads and beards. The homes and shops of many were gutted and the race which was considered fierce felt powerless at the hands of the mob. Though there were many instances of help from neighbours there were also cases where neighbours were instrumental in the destruction of their homes and lives. Experiences like this have far reaching consequences and create a sense of loss of faith in humanity.

In working with survivors it is important to not just focus on the individual's story but also delve into the collective narratives within which people define themselves. Research indicates that people's ability to deal with adversity was dependent on the coherence of their narrative about their life history rather than the actual history of what they had endured. In Gujarat I heard many stories from people describing the bravery and resilience of 'Kutchies', a community from Gujarat, who have survived many adverse conditions owing to their infertile lands and proximity to the sea.

The narratives express the way people create meaning, organize their belief systems and communicate these to each other. In this way narratives are not products of individuals but 'collective co-constructions' (Papadopoulos & Byng-Hall 1997). This approach enables

the therapists to understand communication from people as collective co-construction. It also allows people to mutually co construct with the therapists. It also helps the therapist to examine how stories develop and affect clinical work in relation to the therapist's own story and that of the survivors. Shared narratives also play an important role in the humanization of people's experiences of inhuman treatment. If not shared, the survivors may compartmentalize their experiences or unhealthily repress them. Once shared, collective narratives can have a healing effect as these experiences can be seen in the wider context of life's experiences.

In a group interaction in Punjab, women expressed sentiments of "sadness locked in their hearts" as was also reflected in their eyes and talked, cried and shared with all others. It seemed to make them `lighter',` to be heard by others', to be understood by others and to be able to freely express their anguish without fear of rebuttal'. This sharing brought the group together. The women felt bonded and understood by others who were genuine and caring enough to share and listen. As Gurbant Kaur from Batala said *"We shared our joys and sorrows. I feel light in my heart sharing with others, I feel encouraged to move ahead in life. I don't feel alone in my grief....."*

Storied communities

In simple words it means group of people who are joined together by certain shared narratives. A storied community may provide coherent narratives, which help, in creating resilience and also provide transitional space, which can act as a secure base. The collective and coherent narratives may provide not just secure base but also a sense of continuity and meaning. Collective stories of endurance (not heroism or victimisation) may come to the survivors aid at this critical juncture. Folklore or spiritual structures may provide the collective contexts within which individuals may be able to contain their unbearable pain and even render it meaningful.

These were the major themes that have been the focus of my work. It is just the beginning and in the process of rehabilitation, I must admit that this has been a very humbling experience and has changed my own perspective of seeing people as survivors rather than victims. Through working with people, bonding with them and helping them connect to their own resilience, I have found tremendous opportunities for growth within my own self.

KASHMIR AND WOMEN

Urvashi Butalia
Journalist

1. Throughout the world, the discourse on terrorism leaves out women, seems, increasingly, to be a confrontation on a 'dialogue' (if one can call it that) between men.

2. Yet, women are affected by terrorism in very particular ways and it is important we keep this in mind.

3. This is nowhere more evident than in Kashmir and the North-East, two states which have been in the grip of insurgency for many years.

4. In Kashmir, there are now large numbers of women who are widowed, and those who are 'half-widows' whose husbands are presumed killed but no one knows. These women cannot even have access to compensation because in order to do so, they have to produce a body, to prove death. And of course there are no bodies.

5. There are also large numbers of orphans, and because state services have fallen into disuse and disrepair, there are hardly any institutions that can take care of these orphans.

6. For the young, both men and women, there is nothing to look forward to. They grow up in an atmosphere where violence is the norm, where the gun is something that is revered or seen as a symbol of power. Added to this is the fact that there are no jobs to be had, no real careers to look forward to, and in this scenario, militancy offers at least a possibility of 'glory' and becomes very attractive.

7. As we know from recent years in India, the language of militant nationalism, which is what terrorists deploy, is extremely attractive to women (witness the Hindu Right's successful mobilization of women). And there is increasing evidence now that women form the new and committed cadres among militant movements, particularly in the North-East. Such participation in militancy and violence offers women something they have never had access to the public space, a sense of power, a voice.

8. In Kashmir, what is very evident now is the deep-rooted impact of militancy on the health of women. Trauma, stress, frequent abortions, rape, all these are commonplace, and there are absolutely no services to deal with this. Not only are states not equipped to deal with such problems, the state of services in places like Kashmir is such that they may as well not be there. Large numbers of doctors have fled, and serious medical processes are taken care of by inexperienced people.

9. There is also a considerable increase in violence within the home. Men who are utterly brutalized outside, bring this violence into the home but because of the 'external'

condition of the place and people, so to speak, this 'internal' violence comes rather lower down in the hierarchy of violence and is not therefore given serious consideration. As a result, relationships within homes start to break down, and families fall apart.

10. The fact of militancy and the fear that children may be pulled into it, or girls sexually assaulted, makes women take their children out of schools and bring them into homes, where they are then put to work to earn money and this leads to an increase in child labour - this is now evident in Kashmir.

11. The imposition of dress codes and the threats to women's liberty and movement are well known and I don't need to go into them here.

12. These are some of the more evident things. Underneath these lies the atmosphere of fear and mistrust that is created where one does not know if even close relatives or friends can actually be trusted. In such circumstances it is difficult to even speak about what you are going through with anyone.

13. Women are also often forced to give shelter to militants or to be messengers for them, and often they do this because they are in very bad situation economically and need money to keep the family together. In a similar way, the insecurity created by militancy, and the loss of their men, often pushes women into prostitution and sexual slavery.

14. Finally, and this may not be very popular point, but it is clear that the oppression of women in Kashmir is not only at the hands of the militants, but also, and increasingly, at the hands of the security forces who see women as mere property and who rape and assault them repeatedly. The fact that there are also thousands of disappearances of men and young boys who are picked up by security forces on suspicion of militancy and then tortured, killed or simply not returned, is something that leaves the women extremely vulnerable and unable to cope. The suspension of human rights in situations like this makes things much worse. All of this increases sympathy for the militants and turns women against the State.

MENDING THE MIND: ADDRESSING MENTAL HEALTH CONCERNS

Dr P Ngully
Naga Peoples Movement for Human Rights
Nagaland

INTRODUCTION

Next to the gift of life, good health is a person's most prized possession. For indeed, it is good health that would propel a person to be most productive and creative, bringing about prosperity. Thus there is a tremendous investment in health, by the individuals, families and the governments. But more often than not the mental health component of the total health is found neglected without realising that a human being is basically a thinking and feeling being. In Nagaland, it is only in recent times that attention is being focused on mental health. Interestingly, the relevance of mental health among our people gained importance as a result of increasing problems associated with alcoholism and other substance abuse. In the search for its cause in the domain of the mind we stumbled on the existence of mental health problems, the extent of which was hitherto unsuspected. It is this area and the efforts taken to address the mental health concerns that I would like to present my paper.

Post-Traumatic Stress Disorder (PTSD)

Psychological difficulties after exposure to major stresses have been acknowledged from the beginning of recorded civilization[1]. However, psychiatric interest in the problems of survivors of severe trauma has been aroused only during the past century. Indeed, the development of recognisable psychiatric symptoms following psychological as opposed to physical trauma has always been controversial[2]. This is probably because of the subjective nature of patient's symptoms. So as a psychiatric diagnosis, Post-Traumatic Stress Disorder is relatively new, but there is no question however, that the symptoms of the disorder typify survivors of traumatic abuses or events as well as other types of human-induced stress[3]. Inevitably traumatic events or abuses whether physical or psychological leave scars. Walton T. Roth (1988)[4] has stated that "psychological trauma elicits a variety of cognitive and affective activities varying from person to person which can include cognitive coping strategies, unconscious defense mechanism, depression, anxiety and even hallucinations and delusions." In addition, it is common for survivors to exhibit a

---

1 G. Jackson; R. Roset; Response to Traumatic events. Recent Advances in Clinical Psychiatry - p. 165.

2 Post-Traumatic Stress Disorder and subsequent commentary by Horowitz; Mardi, J; Weiss; Daniel; Lindy, J.P.; Green, B.C.; Grace, M.C. and Ursaro, R.J..
J. Nerv mental disorders 175: 75-76.

3 Glenn R. Randall; Ellen L. Lutz; Serving survivors of torture, American Association for the advancement of Science p. 30.

4 Roth, Walton T. (1988). The Role of Medication in Post-Traumatic Therapy, Ochberg, Frank, Editor, Post-Traumatic therapy and victims of violence, New York; Brunner/Mazel, p. 41.

variety of other psychological response to their trauma including substance abuse to mask psychological sequence, maladaptive attempts at coping and psychosomatic complaints[5].

The findings from our own study[6] carried out on the victims of the 27th December 1994, Mokokchung incident revealed that out of the 115 victims studied 81 (70.43%) were found to be suffering from PTSD. The victims who were in a festive and holiday mood were suddenly and unexpectedly caught up in a terrifying and horrifying sequence of events lasting for a period of four hours. The victims not only survived the merciless brutality of the Army but were also witnesses to the gunning down of persons, looting, destruction and burning down of the buildings, hearing the shrieking voices in agony of those persons who were being roasted alive. The women who were invariably stripped of their garments which were rolled into balls then soaked in petrol and thrown into the burning building. Some of the soldiers taking advantage of the terror stricken people dragged some of the women folks into shops and raped them at gun point.

The victims were totally cut off from any outside help or support from friends and relatives. They were absolutely at the mercy of the brutal army who were actually charged with the responsibility for ensuring their safety and well being by the government. The victims came to know first hand, the depth of human cruelty. Their sense of invulnerability was lost as a result of being rendered helpless and dependent on those whose purpose was to harm them and also being stripped of the right to make rational choices, such as to care for themselves at the most fundamental levels, or to help others. As stated earlier, the study carried out almost nine months after the incident revealed 70.43% were suffering from PTSD, out of which 95.06% were having recurrent and intrusive recollections of the events; 83.95% were still continuing to suffer from distressing dreams of the events; 88.88% were acting or feeling as if the traumatic event were recurring; 91.36% were suffering from intense psychological distress at exposure to internal and external cues that symbolise or resemble any aspect of the traumatic events; 95.06% were found to have physiological reactivity mostly in the form of perspiration and breathlessness on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event; 65.43% were found to be unable to have loving feelings after the trauma while 96.60% were found to be having difficulty in concentration and 66.66% have lost self-confidence and developed a sense of foreshortened future.

In another study carried out on the tortured victims, 22 months after the Oinam incident, noticed a high rate of PTSD. They also found an unquestionable relationship between the type and nature of torture with their symptoms, like recurrent distressing dreams of the event, falling and staying asleep, recurrent and intrusive painful recollection of the torture etc. The barking of dogs, sounds resembling gun shots, sight of olive green dress and even colour, sound of jeep, sound of helicopter and sounds of children running downhill simulating marching troops, still disturbed these victims with vivid memories of torture and intense psychological distress.

---

[5] Glenn R. Randall; Ellen L. Lutz; Serving survivors of torture, American Association for advancement of Science p. 2

[6] Ngully, P. et al (1995). Post-Traumatic state of mental health; a medical study on the effects of trauma on mental health of the victims of the 27th Dec. 1994 Incident at Mokokchung, Nagaland.

These two studies of recent times only reveals the tip of the iceberg of psychiatric morbidity subsequent to 'man-made' disaster. The full picture will only emerge after taking into account all repressive measures unleashed on the Nagas from the day they asserted their rights to self-determination. The way their villages with their granaries were razed to grounds and burned to ashes, the way they were uprooted from their villages, grouped and herded together like animals and kept in 'concentration camp' like situations where, torture, brutal killing, disappearances and rapes were common. Such cruel militarization besides totally destroying their economy has left a deep scar on the mental health of the people.

Addressing mental health concerns

The way to a meaningful life has never been an easy one but, it seems so much more difficult in the present times. We have become fearful, suspicious, dishonest, corrupted, self-centred and crooked with a foreboding sense of fear and disgust mixed with hatred and violence. No wonder our youths are taking to drugs and alcohol as fish to water and the adults are continuously complaining of pain and suffering with no relief from any medication. All these indicate a mental health far from healthy as uncovered from the few studies. Thus we have begun to address these mental health issues through the various social organisations which I will mention in brief.

I. The Naga Peoples Movement for Human Rights (NPMHR) – The NPMHR has initiated two programmes

(a) Workshops: The NPMHR conducts workshops calling it as "A Strategy of Hope". These are workshops where leaders of various organisations are made to participate. Each workshop caters to not more than 30 participants at a time. The workshop discusses at length about the impact of conflict on mental health such as PTSD. The sessions are followed by dividing into groups for group discussions on issues such as –

(i) Conflicts within the social set up.
(ii) Impact of PTSD on a society experiencing a state of conflict and ways to effectively confront it.
(iii) Evolving alternative ways to provide basic mental health care in conflict areas.
(iv) Creating strategies to confront psychological warfare.

Through this workshop we work out our plan of action relevant to the particular place to be carried out by the local leader of the organisation who attends the workshop. Adequate information is also made available to the participants about the professional help that is available locally and within the state.

The first such workshop was conducted solely for the Naga Mothers' Association in Kohima in December 1999. Following which upto now we have been able to conduct only three more workshops of this kind. Depending on availability of resources and time, we plan to conduct more such workshops in the times to come.

(b) Journey of Conscience: The NPMHR has launched a "Journey of Conscience" in January 2000 going to various places within and without the Naga areas. During such journeys, time is taken to address the mental health needs, where people are encouraged to freely speak of their own experiences either in public or in private. Then we discuss about the futility of vengeance and that only forgiveness frees us from the injustice of others. For apart from forgiveness, the monstrous past may awake at any time from hibernation to devour the present and also the future. Indeed if everyone as observed by Mahatma Gandhi followed the "eye for an eye" principle of justice, eventually the whole world would go blind.

II. Nagaland Doctors' Association – From time to time, the Nagaland Doctor's Association conducts multi-speciality health camps in the remote areas. It is at such time we try to meet the mental health needs of the affected people.

III. Naga Mothers' Association – The NMA has been trying to address the issues of drug addiction and substance abuse through sensitization of people to understand addiction as a disease needing proper care and treatment rather than just moralising. Treatment centres have been established to meet such needs.

IV. The Churches – The churches have been making tremendous efforts to bring about an end to conflicts through mutual understanding and compassion, and by healing the wounds through the Biblical vision of turning the swords into ploughshares.

REPORT ON THE PLIGHT OF TERRORIST AFFECTED FAMILIES IN GURDASPUR/AMRITSAR DISTRICTS

Ms Shabnam Handa
Principal, DAV School, Batala

Punjab became prototype 'Gaurnice' paired with pubating bloods of its own sons and daughters. Although I had not, but the 'sands of time' eye witnessed the blowing of buses carrying non-combatants, assassination of businessmen, kidnapping of school children, hijacking and holding innocent men and women as hostages who became direct victims of terrorists. I have these incidents imprinted on my psyche. In the dark decade of militancy, there was darkness at noon in the houses, villages and cities. Life shirked inch by inch. A knock at the door was not a signal of an approaching guest but it became a warning of lurking raid by terrorist or the police. The once jubilant Punjabis had forgotten their festivities. The citizenry of Punjabis in its totality was under attack. Once everybody was victimized and was made silent then only the silence echoed with its tentacles gnawing the pulse of life. Those who had gone through the fire to enter our hearts were forgotten by the society. Survivors of the violence became worst victims. Relatives and friends of victim families shirked to console them under phobia of being the target of the terrorist as well.

During this phase, I was away in Ghana (West Africa) with my husband where both of us were teaching on contract with the Ghana Government. Information about the incidents of violence percolated through letters from family members in India and abridged radio broadcasts. It had a drastic impact on us because my hometown Batala district Gurdaspur, Punjab was the worst hit town. Batala had to undergo maximum number of bomb-blasts as compared to any other town and city in Punjab. I felt the insecurity of my mother, brother, relatives and friends reeling under the trauma. We were not ready to believe the news as such because of our own psychological defense mechanisms. Finally, on our return to India in 1991, when we tried to confirm the information received at Ghana, we could only find that those were only understatements. In the year 1992, which was the fag end of the militancy, I had the spine-chilling experience on a visit to the family of my brother's friend who along with his only brother were mercilessly shot dead in a bus by the terrorists without any grudge against them. The scene of uncontrollable wailing mother and sisters over the dead bodies of the two boys or young hopes has left a permanent scar on my being.

Against this back-drop of horrifying hues of violence, Mr Vivek Mishra the then Superintendent of Police (S.P.) Headquarters, introduced me to project "INTERACT" of Rajiv Gandhi Foundation. At that time I was discharging duties as Principal of Dr Daulat Ram Bhalla, D.A.V. Centenary Public School, Batala which is run by D.A.V. College Trust & Management Society, New Delhi. Since 1996 I have also been working as member of Lok Adalats conducted in Batala by the Honourable Punjab and Haryana High Court, Chandigarh and also as member of Advisory Committee, Women Police Cell, Batala. The proposal of Mr Vivek Mishra, S.P. Headquarters, to lend a helping hand to Batala Police

for the project "INTERACT" of Rajiv Gandhi Foundation was the God sent message as I was unconsciously waiting to do something for the survivors of the terrorist acts.

Subsequently I attended a training programme cum Workshop under 'Counselling Support for Dealing with Trauma' held at B.D. Arya College, Jalandhar from 22nd to 24th July 2000 organised by Rajiv Gandhi Foundation. After the Workshop, I was nominated as paracounsellor for the Rajiv Gandhi Foundation and was given the charge of about 120 members of terrorism affected families of Gurdaspur and Amritsar District.

My specific responsibilities included :
1. Identification of children/mothers with problem, and providing counselling support
2. Organising activities for the children, at least twice a year.

In order to familiarise myself with the members, a day long camp was organised at our school in Batala on Sunday, 1st October, 2000. Almost 150 members (children and their guardians) turned up for this camp. The main focus being to bring some cheer in their lives. Various competitions like painting, quiz and antakshri were organised for the children whereas the women folk participated in musical chair & ladies sangeet. Several children took part in sports activities & yoga practices that were also organised by us. It was indeed heartening to see that for once, children and their guardians forgot all about their personal worries and participated in all the activities very enthusiastically. Later on the parents/guardian accompanying the children also used this opportunity to discuss their specific problems.

A second meet was organised for children studying at secondary and senior secondary level along with their guardians on 17th Feb, 2001. Mrs Arvinder J. Singh addressed this meet in which children and their guardians brought up the problems faced by them for their higher studies.

My experince has been that in most cases the problem faced by these families are financial. For the civilian victims of terrorism, Punjab Government is providing a fixed amount of Rs. 2500/- per month as family pension. They have free travelling facility in State Transport buses. They have also been issued 'red cards' on the basis of which they can be considered favourably – for a job in any government department. No such facility is extended to the victims of the police departments. Apart from paying an amount of Rs. 1,00,000 ex gratia the State Government has done very little to rehabilitate the affected families from the police. These families continue to face exploitation and tremendous sense of insecurity still prevails in their lives.

Here I would like to share a few cases that the affected families have discussed with me:-

Case I

Assistant Sub Inspector Kashmir Singh was killed in an encounter between the Punjab Police and some dreaded militants. President's gallantry award was conferred on him posthumously. His elder son, Jatinder Singh, who with the help of Rajiv Gandhi Foundatiom

has completed his education up to senior secondary level is now studying in a college. Jatinder, who excelled both in academic & sports activities at school level, wanted to join the Punjab Police as an assistant Sub Inspector like his father. He feels highly dejected on having been told by the Punjab Police that he could only be considered for the post of a Constable.

His mother who was all praise for Rajiv Gandhi Foundation for providing the financial assistance to her two sons for their education, feels that compared to the Central Government who did so much for the families of the martyrs of Kargil, the Punjab Government has done very little for the welfare of the police who fought terrorism in Punjab. She is now feeling highly troubled by seeing persons like Jagjit Singh Chauhan being allowed to return to India by Punjab Government, who, she feels were responsible for so much upheaval in the society during terrorism. She finds it ironic that they are returning to India, under the pretext of meeting their family members after the gap of 10–15 years whereas people like her have been forced to live their lives without their life partners for no fault of theirs.

I meet the family whenever I go to that area. The family appreciates whatever little guidance I am able to offer to the children. I would like to help the children avail of some benefits from the Sports Authority of India and have discussed this with RGF so that they can follow it up at their end.

Case II

Another Rajiv Gandhi Foundation beneficiary, Rajpal Singh stands implicated in a murder case that his mother Dalbir Kaur claims has been framed on her son by her husband's killers. Today Rajpal finds his life totally ruined. His case is being tried in a Juvenile Court in Gurdaspur. He has nobody to plead the case on his behalf. His mother is being constantly harassed by the villagers making life totally unbearable for her. Personally, after Rajpal Singh visited me twice, I have decided to make a representation to the Sessions Judge on behalf of his family.

Case III

Dimple, a young girl whose one leg is afflicted by polio, was studying in a boarding school that was 15 kms away from her village. Her family members instead of continuing her education wanted her to do all the menial jobs in the house as well as look after her brother's children. During one of her visits, she confided in me that her own mother did not want to send her and bring her back from school. She said that she wanted to continue her studies and implored me to engage her in my school after her graduation.

On my part, I have got her admitted in a government aided D.A.V. School near her village where she is now quite happy and being looked after by the school staff in the best possible manner.

Apart from these, there are cases where the affected women have been physically exploited by the male members of their husbands' families, leading humiliated lives and treated as

social outcasts by the society in general. Attempts have been made to make arrangements so that they can lead peaceful and dignified lives along with their children, forgetting their traumatized past.

Recommendations

1. In most cases the affected families have financial problems. Apart from the help provided by the Rajiv Gandhi Foundation, they have no other source of income. It has also been noticed that the public at large is not aware of steps being taken for them or the problem being faced by the victims of terrorism, even though it is ten years since militancy waned in these areas. We need to highlight the plight of these families by organizing some special fora at the district level where some big entrepreneurs and benevolent members of the society could be asked to provide more financial assistance to these families or to engage the children of these families in their factories on completion of their school/ college studies.

2. Organizations like D.A.V. College Managing Committee, New Delhi which has about 600 educational institutions running successfully throughout India can be approached through it's President, Honourable Padamshree G.P. Chopra Ji so that free education can be extended till the highest possible level to the children of terrorism affected families.

3. More interactions among the victims are needed at regular intervals as it always gives them opportunity to give vent to their feelings. The para-consellors are able to listen to their individual problems and give suggestions or provide assistance where ever possible. The camps organised by us help in creating new bonding among the victims and they are encouraged to focus on their future and get on with their lives rather then think about past and the traumatic events that have occurred in their lives.

In the capacity of Principal of a prominent school, although I could not devote much to these families, I felt a sense of fulfillment when I found that most of them felt immensely relieved after the interaction and discussion of their personal problems with me. Now I intend dividing them into smaller groups, area wise and encourage them to organise activities and social gatherings so that they can try to sort out their problems among themselves by lending a helping hand to each other. We cannot fill the void in their lives but at least we can assure them that they are very much part and parcel of our society.

Before parting, I would like to add that the children of the slain terrorists should also be considered as the victims of terrorism because they are equally under the psychological, social and financial trauma for no fault of theirs. These children were never party to any act of terrorism committed by their family member. By doing so, RGF can also show its concern to these altogether neglected and destitute children who are being exploited in more than one way.

Dear friends, I am confident that we shall return home from this seminar and dialogue, more determined and better prepared to do whatever we can do to put life into the existence of our bigger self i.e. our fellow survivors, although we had inherited an easy world.

ROLE OF CIVIL SOCIETIES IN MENTAL HEALTH OF PEOPLE IN CONFLICT AREAS

Abdur Rasheed, Journalist, Greater Kashmir, Srinagar
Sofiya Mir Hasan, Better World, Srinagar

Mental health has been a non-issue particularly in the under developed and developing societies till not so distant past. It was perhaps during the twentieth century that people became conscious of it. Till then, the major areas of concern were the all pervasive poverty, ignorance and disease. In the arena of healthcare, it was mainly the physical aspect that got attention even as mental disorders were not so uncommon. Necessity is the mother of invention, they say. Incidence of disease necessitated response and eventually provided the sum and substance for the modern day medicare. Over the centuries, the response to the variegated problems of disease progressed for the general medicine and surgery to super-specialization or in other words from macro to micro levels of treatment.

Mental health

Need for mental well being as distinct from mere physical health is as old as perhaps the mankind itself. Most forms of human behavior can be attributed to the mental state of an individual. Many a physical ailments too are traced to mental trouble. Who can deny that a whole range of research has thrown up a specialized branch of knowledge known as psychology. The subject deals exclusively with the phenomenon of mind and its related aspects. Nevertheless, there is no denying the fact that human welfare as a whole is directly dependent on the atmosphere that prevails in a place. It presupposes peace and tranquility within and outside. However, through its chequered past, countless trouble spots have emerged all over the globe. Conflicts related to social, political, ethnic, religious, economic, cultural and other issues are galore. Even in a family, there can be conflicts among its members. Transcending the limited confines of home, conflict situations can, and indeed do spill over to groups, classes, neighborhoods, communities and even nations and countries with disastrous consequences after assuming violent dimensions. However, once a conflict leads to violence, the fallout can be unforeseen in its extent and magnitude in more ways than one. Large scale of destruction of life and poverty can inflict not merely the physical loss and deprivation, it can also result in deep emotional scars. The accompanying trauma can have devastating consequences on a whole lot of people, particularly those affected directly. In case of the trauma resulting from political or religious conflict, the group inflicting pain, suffering and despair on its victims is easily identifiable. Such a trauma affects large groups of people in ways entirely different from the effects of natural or accidental disasters.

Conflict situation in J&K

Because of the well known historical reasons, Jammu & Kashmir has been experiencing frequent bouts of socio-political turmoil, very often even resulting in violence. These tensions have dogged the relations between the State and the rest of the country overtaking the situation from time to time resulting in disturbances of varying scales. It was in 1987, that

the unfortunate mass rigging of elections coupled with rampant corruption forced the youth to resort to violent methods to give vent to their pent up grievances and feeling of neglect. Over the past 12 years particularly, the conflict situation has assumed nauseating dimensions. According to reports, the unbeaten cycle of gore and mayhem has already consumed nearly 80,000 people, mostly youth. Thousands of others have been maimed, many more traumatized. Modesty of tens of hundreds of women has been outraged. Private property and public utility assets worth thousands of crores of rupees have been destroyed. In fact, the magnitude of loss and suffering defies description in cold statistics, it's simply astronomical.

However, the psychological costs of the conflict situation both for the civilians and combatants are being understood and recognized only now. According to reports, 80 to 90 percent of those suffering from the resultant violence are believed to be civilians. Of them, the women, children and the aged and infirm are the worst hit. By any stretch of imagination, it may require a Herculean effort spread over decades of research to assess the loss resulting from militancy in Jammu and Kashmir whose end is still nowhere in sight. The State Government is preoccupied with the problem so much that it has little time to undertake an extensive assessment. It was a UK-based organization, Save The Children, which sponsored a sample survey and charted the Department of Sociology of the Kashmir University during 1998-99 for the job. The survey was carried out by Dr Bashir Ahmad Dabla and his team of researchers.

Women and children

Knowing that women and children were the most vulnerable segments of the society to the adverse fallout of the violence, Dr Dabla and his team surveyed all the six districts of the Kashmir valley taking 50 respondents each of orphans and widows. In all, 300 orphans and as many widows were questioned on specific aspects of what is known the Post-Traumatic Stress Disorders (PTSD). Around 80 percent of the children had been witness to killing of their fathers. Findings of the survey were revealing. With barely nine percent of the widows marrying again, the bulk of them preferred to lead a life of celibacy to provide the much needed protective cover to their children. More than 65 percent of them, kept their children with themselves. The remaining 35 percent widows developed some traits related to social control and deviation. The common problems of widows faced are of three broad categories: (a) emotional stress, denial of inheritance, sexual harassment and social undesirability; (b) mismanagement of domestic affairs, losing control over children, inferiority complex and loss of child career; and (c) loneliness, physical insecurity, compulsion for remarriage, overburden of domestic and other works.

Support system for the affected families was provided mostly by relatives, individuals, government and non-governmental organizations. However, 70 percent of them are not satisfied with the procedures and amount of support. In most cases, the support is either delayed or altogether denied. At this point what appears to be a patently discriminatory approach to the support cover being provided by government & non governmental agencies is that the children of militants rendered orphan are denied any financial assistance for their maintenance, health care & education. After all, these children cannot be held guilty

for the ideology their deceased fathers pursued. In fact they deserve it more than the children of those not involved in militancy.

The need of these families related mainly to education of children, healthcare, economic independence, marriage of children, housing and jobs. As for the orphans, 85 per cent of them live with their widowed mothers. Most of their crucial problems are: economic hardship 48%, psychological set back 22%, denial of love and affection 14% and apathy of relatives 9% while 73 per cent of these children are school going (class 1 to 5 : 53%, 6 to 9 : 33% and class 10 and above 14%), 27 percent have dropped out or are non school going primarily due to low awareness, death of father, and accompanying poverty. The dropouts are engaged in domestic work (4%), handicraft (38%), automobile workshops, business houses & non-governmental service (4% each).

Various problems the ever-swelling number of orphans face are: loss of education and career making, halting of hobbies, loss of regular income, negative social attitudes, deterioration of health, negative personality growth, undesirable socialization, bleak matrimonial prospects, denial of property rights and social deviation. It has been observed that most of these families have developed a strong urge for peace, religious ethos, social justice, high literacy, right to independence, progress and development, and a society free from disease, stress, conflict besides active cultural life.

Negligible response

Obviously, the colossal destruction and loss that Kashmir has suffered over the past 12 years would call for a massive response at various levels, governmental & voluntary. But, like in most other spheres of individual and collective life, in this area also, the response is either pathetically negligible or none at all. Sadly, the State Government has lost its sense of priority, for some dubious considerations, relishes investing huge sums in inconsequential, un-productive, and even out rightly irrelevant pursuits. Pretty little has so far been done to address the mental health concerns of the vast multitude of militancy-hit people. The extent and magnitude of the problem can be appreciated by the observations of the noted physician, Dr G Q Allaqband, at a recent workshop the Rehabilitation Council had organized at Srinagar. He was candid to assert that 100 percent of the people in Kashmir suffered from one or the other mental disorder. Indeed, a sizeable section of the medical fraternity in the valley, apparently in full agreement with Dr Allaqband, believe majority of the people show various symptoms of Post-Traumatic Stress Disorders (PSTD).

The Problem

In any case, the most conservative figure of those suffering from psychological problems is believed to be more than 70 percent. The problems comprise anxiety disorders, depression and PSTD. The common responses of adults to various traumatic events have been fear, tension, confusion, grief, depression, feeling of shame, guilt, irresistibility, and physical complaints. Those among the children are fear, crying, screaming, moodiness, aggressive behavior, disobedience, rebelliousness, headaches, stomach aches, feeling of shame, frightening thoughts and the like. Most of these are not easily recognized,

diagnosed or treated properly and effectively due to which the patients have to move from doctor to doctor and eventually end up thoroughly shattered and broken.

Education and Health

Education and the medical establishments could have been the two areas which could play a pivotal role in shaping an effective response to the nasty problems related to mental health. Both are awfully ill equipped to live up to the expectations. There is need to incorporate the subject in the curricula applied at the undergraduate, graduate and postgraduate levels. The existing syllabi are bereft of any component about mental health. In the field of teachers' education at all the three levels, there is no provision for mental health and orientation. Majority of teachers receiving training in basic education, or those having undergone more specialized B. Ed or M. Ed courses, are pathetically blank in mental health issues of their pupils.

The solitary hospital for psychiatric diseases at Srinagar is absolutely no match for the gigantic mental health problems in the valley. Following mysterious fire incidents allegedly triggered by the officials themselves from time to time, the hospital is in veritable shambles. It suffers from pathetic inadequacy of men and material. According to some experts in the field, the ratio of psychiatrists available is an extremely disturbing 1:2,00,000 (one to a population of two lakh). The situation is further compounded by the inadequate knowledge and training in psychiatry.

According to the noted psychiatrist, Dr Mushtaq Margoob, the number of patients reporting at the outpatient department of the hospital was a mere six in 1990. Over the years, it has gone up to an alarming 250 to 350 patients a day. PTSD is the most common problem. These manifest themselves in all pervasive fear, confusion and anger. While children and adults show fear, adolescents display anger and confusion. At a workshop organized by the Amsterdam-based NGO, Medicins Sans Frontieres (MSF) or Doctors without Borders at Srinagar, Dr Margoob suggested sustained interaction between NGOs and the medical establishment; teaching psychiatry as a compulsory subject; and meditation and spiritual treatment by involving faith healers as some possibilities of addressing mental health problems.

Civil societies' role

Eventually, it is the civil societies which have to rise to the occasion and evolve a matching response to the immensely disturbing situation on the mental health front. In a situation such as that in the strife-torn Kashmir, their role cannot be over-emphasized. Genuine non governmental organisations with their roots in the affected population, can face the enormous challenge more effectively. They can pave way for the eventual bio-social regeneration of the affected people. For this purpose, involvement and training of community workers, health workers, Integrated Child Development Scheme (ICDS) functionaries, teachers, village elders, and even religious leaders in the much needed counselling skills cannot be wished away. They are the ones who, in tandem, can create the desired impact. Short-term trainings in common psycho-social problems would be needed to give them an orientation for the task. Without waiting for the more sophisticated

and specialized response, these barefoot counsellors, need to be sensitized so that they can provide what it known as the psychological first aid to the affected people. Through them, a comprehensive psycho-therapic intervention can be organized. Greater interaction should also be promoted among non-psychiatrists, physicians and psychiatrists.

The civil societies will need to concentrate on the following specific roles:

- To work with survivors to help them help themselves.
- To build the survivors' resilience and ability to withstand crises.
- To organize group meetings for rebuilding social and community links.
- To visit the affected families at least once a month and particularly on festive occasions like birthdays.
- To identify possible sources and avenues of help and to help the survivors to get it.
- To encourage play, drawing, story telling and drama among children.
- To organize career guidance for older children.
- To tap the positive potential or 'star qualities' of survivors and prevent negative tendencies or 'monster attitudes' from striking roots in their mind.

Rajiv Gandhi Foundation's Pioneering Role

Luckily, it was the Rajiv Gandhi Foundation that eventually seized the initiative to pioneer a multi-dimensional effort to address the mental health concerns of those affected by the militancy not only in Jammu and Kashmir but elsewhere also. The Foundation has been providing the much-needed financial succor for hundreds of school-going children rendered orphan by the 12-year long militancy. It began the activity under its project INTERACT in late 1993 in Kashmir valley. The Foundation has so far disbursed about Rs. 40 lakhs to nearly 180 such children to enable them continue their education. On the mental health issues, the Foundation began its activity by organizing a 3-day workshop at Srinagar in June last year. Representatives attended it from various NGOs viz the HELP Foundation, the Better World, the Society for Rural and Urban Development, the Voluntary Health Association of India, and the Kasturba Gandhi Memorial Trust. During the workshop, the participants were imparted rudimentary training in counselling skills. To begin with, they interacted with the guardians and children getting the education and maintenance assistance from the Foundation under the project INTERACT.

Training of para-counsellors

The Foundation organized another 3-day workshop with the NGOs representatives and individuals interested in the field this year. It was in the nature of a follow-up of the last year's workshop. At its instance, an indigenous group of para-counsellors drawn from amongst social activists, government officials, journalists, medical practitioners and NGOs was formed at Srinagar. This group has embarked on the uphill task of organizing a long-term and comprehensive response to the valley's growing mental health needs. The major goal of the core group is to take such an initiative which will start a mass movement in the valley. No doubt, there are other organizations as well who conducted workshops on mental health but, RGF's effort to carry out the work through the core group is excellent. Through professionalism and a systematic work in the area of mental health, RGF's effort

has created a significant impact. During the group counselling, the core group facilitates interaction among children, who themselves start sharing, healing and caring process. Experience of one child helps and is useful to others. There are possibilities of individuals who have survived severe stress like torture, having developed coping strategies that could be useful in therapy of others.

The family is being utilized as an essential resource for counselling. The principles of family dynamics are used to facilitate supportive and healing relationships while discussing various problems. The core group goes to the families and unburden them by listening to them, and making them feel relaxed and comfortable. Ever since its launch, the core group of counsellors has held several workshops at individual and group levels to generate awareness about mental health issues. Its members interacted with orphans, widows and destitute at various places like Saidakadal, Shanpora with appreciable results. The INTERACT children are under a closer focus of the group. Some more enthusiasts have evinced interest to join the group in the voluntary effort. In any case, this is a humble beginning on a long journey in a place spread out far and wide in the valley.

Sofiya Hassan's Experiences

During an interaction with many women and children directly affected by turmoil in their families, I found them totally disturbed & depressed. They have a feeling of total loss & mistrust. I would like to share a few cases:

Once I met an 11-year old boy working in a shop as a sales boy. He had dropped-out of school after the death of his father. While talking to him I found him very earnest and pushing. He had not fully reconciled to giving up his studies midway. Every morning he used to see children going to school. This pinched him at the deep core of his heart. But within no time he got adjusted with the changed situations as he found himself compelled to shoulder his domestic responsibilities. Sometimes he fails to adjust and wishes to have a schoolbag on his shoulders.

One more case is that of a family in a down-trodden area where in the sole bread earner is no more. When I talked to the widow, her two daughters and three little sons with no source of income, she opened up and said, "You know some times I and my daughters want to take poison." Is it not depression? "Coping up with the circumstances is not as easy as it seems" she added.

Before it is too late we must speak out, act fearlessly and urgently. And so out of the fire of fear and frenzy, create a way to sanity and peace. Indeed, all these are some small beginnings in the stupendous task of applying the healing touch to the vast multitude of survivors of the unending violence in Kashmir. Much more is yet to be done. Of course, the dearth of committed mental health workers and paucity of resources is too frightening for those already in the field. Nevertheless, as they say, for every journey, there has to be first step. And, that has been taken, indeed, with abiding conviction and confidence.

Annex A

RGF MENTAL HEALTH PROGRAMME

RGF's concern about the mental health of people affected by terrorism stems out of its first hand experience of interacting with the children and their families affected by terrorism. RGF supports the education of about 1200 children who have lost their parents in acts of terrorism through its project – INTERACT (*An Initiative To Educate, Rehabilitate and Assist the Children affected by Terrorism*). While interacting with the children and their families closely, it was realised that there were several other unaddressed issues related both to their past and future, which needed attention. Past experiences still haunted them and manifested in the behaviour of some of these children who visited Delhi during the Children's Meets organised for them.

Shabir from Srinagar had a constant headache for several months.

Yasmin complained of pain in her heart and had to be taken to the hospital where the doctor told us that it was due to anxiety. Jaskaranjeet from Punjab faced a similar problem.

Bijeta from Manipur started crying when she saw the mother of another child simply combing her hair. She had lost her mother and missed these simple acts of affection. Her crying started a chain of hysterical reaction by all present in the room.

Gandhi Ram an 18 year old boy would ring up his mother everyday to find out if she was alright. He would get very upset if the call did not come through.

There were many such instances of psychosomatic symptoms. We were aware that these problems, if not handled adequately would lead to more serious problems. It also seemed that this was only tip of an iceberg. As an organisation there are limitations in extending help to resolve these issues. However, we felt that an attempt could be made to help them cope with the trauma they had faced and get on with their lives.

Although the problem was identified, addressing it was an uphill task. These children reside in hundreds of villages spread over the 7 States from where they are identified. A humble beginning was made by having a special session organised for children who had come to Delhi during a Childrens' Meet. Pravah, an NGO based in Delhi helped in organising it. The positive outcome of this session deepened RGF's resolve to address this issue. Several organisations engaged in the area of mental health were approached, urging them to join the programme. A few responded. These were Sampark, also based in Delhi and the Institute of Mental Health, Hyderabad.

Teams from these organisations held residential camps for the INTERACT children and their families (mostly mothers) in Punjab and Andhra Pradesh, which further helped us in shaping up the programme. Children and widows shared their concerns, which ranged from issues relating to their education, financial status, attitude of other family members

and the society at large towards them. Group sessions were found to be very effective in the camps.

A need to develop more focussed interventions for the victims of terrorism emerged. Both medical and non-medical models had been applied in the camps, though mostly the latter was used. To gain a wider perspective of effective interventions, Prof. Renos Papadopoulos from the Tavistock Clinic, UK was invited with the support of British Council. With his assistance, in March 2000, a training was organised for master trainers. Participants comprised of both medical and non medical mental health professionals. This was followed by development of a manual for para counsellors, a term coined to include persons with no formal training in counselling, in the mental health programme.

Children reside at places where it would be unrealistic to expect the presence of mental health professionals. Therefore such persons/organisations were selected who were keen to work in this area. A series of training programmes were held in J&K, Punjab and Andhra Pradesh. The trained para-counsellors independently meet the children and their families. All this work is being done in addition to their regular occupations which makes their contribution very significant. RGF's experience of working with individual volunteers was better than that with organisations.

The camps which were held by trained personnel are now being held by these para-counsellors. These get-together have helped in developing support groups from within the participants. The programme so far was limited to only the families of INTERACT children. However, in Srinagar, after a rather slow beginning a network of concerned individuals and organisations has been formed. This network called CARE-Srinagar has expanded the scope of the mental health programme and its members are visiting institutions and carrying out awareness programme independently.

RGF will support the activities of these groups for about two years during which training programmes and assistance for holding camps etc. will be given to the para-counsellors. While the response to this programme has been enthusiastic, there have been certain limitations also.

Some of these are:

- Identification of motivated persons in the local areas to be trained as para-counsellors is a difficult task. Many trained para-counsellors have dropped out of the programme because they feel it is 'risky' to visit such places.
- Supervision of the trained para-counsellors has not been very intensive.
- Non-availability of mental health professionals locally, to assist those with more severe problems.
- The programme is limited to only INTERACT children and their families.

Future plans:

- Continue to assist the para-counsellors in the three States in forming support groups among the victims.

- Carry out similar programme in the north-eastern states also.
- Network with other organisations working in the area of mental health.
- Advocacy to highlight the issue of mental health of people in terrorism affected areas.
- Try and implement a district level mental health programme at least one of the states affected by terrorism.

Annex B

State-wise Distribution of Mental Health Professionals

State	Psychiatrists	Clinical Psychologists	School Counsellors in Sr. Secondary schools
Andhra Pradesh	88	9	329
Arunachal Pradesh	Nil	Nil	11
Assam	19	Nil	118
Bihar	94	6	156
Chattisgarh	NA	NA	NA
Delhi	134	29	360
Goa	20	Nil	21
Gujarat	102	16	1663
Haryana	34	3	96
Himachal Pradesh	9	6	29
J&K	11	2	30
Jharkhand	NA	NA	NA
Karnataka	181	69	455
Kerala	156	32	95
Madhya Pradesh	33	10	645
Manipur	6	1	13
Maharashtra	376	23	544
Meghalaya	2	Nil	4
Mizoram	1	Nil	Nil
Nagaland	2	Nil	Nil
Orissa	42	2	122
Punjab	57	5	290
Rajasthan	79	26	596
Sikkim	6	Nil	7
Tamil Nadu	192	23	655
Tripura	7	Nil	3
Uttar Pradesh	147	61	72
Uttarkashi	NA	NA	NA
West Bengal	238	10	121
Chandigarh	40	14	6435

Source: Directories of psychiatrists, clinical psychologists 1997; 6th Educational Survey, NCERT, 1998.

Annex C

List of participants

Chairpersons
Justice J S Verma
National Human Rights Commission
Sardar Patel Bhawan
Parliament Street
New Delhi- 110001
Tel: 3346245

Dr Kiran Bedi
Joint Commissioner of Police
New Delhi

Mr R.N Salhan
Additional Director General
Ministry of Health & Family Welfare
Nirman Bhawan
New Delhi-110001
Tel: 3017481
Fax: 3382874

Paper presenters
Dr Pradeep Agarwal
Shubhodaya Centre for Rehabilitation of Victims of Torture and Violence
Basti Vikas Kendra,
Near Hanuman Mandir,
Private Colony, Srinivaspuri
New Delhi- 110065
Tel: 5407220

Ms Arvinder J. Singh
Consultant
C-161 Sarvodaya Enclave
New Delhi- 17
Tel: 4603225, 6511024
e-mail: grover@del2.vsnl.net.in

Dr P. Ngully
NPMHR Secretariat
Opposite WW II Cemetery
251 Midland
Kohima- 797001
Nagaland
Tel: 0370- 223404
e-mail: p.ngully@hotmail.com

Dr Sibyl Jade Pena
Medicins Sans Frontieres
C-106, Defence Colony
New Delhi- 24
Tel: 4603225
Fax: 4626567
e-mail: msfh-delhi@amsterdammsf.org

Dr Shobna Sonpar
Consultant
14 North Avenue
Indian Institute of Technology Campus
Hauz Khas
New Delhi- 110016
Tel: 6856209, 6591914®
e-mail: shobnasonpar@hotmail.com

Para-counsellors
Mr Abdur Rasheed
Help Foundation
6, Tawheed Abaad,
Bemina, Srinagar
Jammu & Kashmir
Tel: 0194-490004, 453768
e-mail: rasheedshahid@yahoo.com

Ms Jyothi Kiran
C/o. George, MIG-675, BHEL
Ramachandra Puram
Hyderabad, Andhra Pradesh
Tel: 040-3024197, 7560918

Mohd. Hazira
Wood Land Asha Neuro Psychiatry Centre
Opposite Provident Fund Building
Burkatpura,Hyderabad
Andra Pradesh- 500027
Tel: 040-7560918
e-mail: hazira_md@yahoo.co.in

Ms Sofiya Hassan Mir
Better World
Better World, P.B. No. 1372
Raj Bagh, Srinargar
Jammu & Kashmir
Tel: 0194-458776
e-mail: better_world@rediffmail.com

Mrs Shabnam Handa
Principal (Para-counsellor)
DAV Centenary Public School
Khajori Gate
Batala- 143505
Punjab
Tel: 01871-41294,46268®

Participants

Mr Abdul Mabood
Ms Jyoti
SNEHI
C/O. Fr. Agnel School
Neeti Bagh, New Delhi- 49
Tel: 6521494, 6534422, Fax: 6521494
e-mail: snehichetna@hotmail.com

Dr Annie Ahonen
Embassy of Finland
Nyay Marg, Chanakyapuri
New Delhi- 21
Tel: 6115258

Dr Bindu Parsad
Indian Association for Family Therapy
52, Godavari Appartments, Alaknanda
New Delhi-19
Tel: 6461097®
e-mail: deviart@ndf.vsnl.net.in

Mr Dev Bharati
ABTAK
Tel: 3243333

Dr Jiban Chakraborty
Chief Financial Officer
Govt. of India
Health Service,Udaipur
Tripura
Tel: 03821- 22221(O), 0381- 325737

Mr Johanna Sarjas
Finish News Agency STT
Tel: 6136643
e-mail: johanna.sarjas@stt.fi

Ms Kiran Masson
IKEA Trading (I) Ltd
Plot No. 8, Balaji Estate
Guru Ravi Das Marg
Kalkaji
New Delhi- 21
Tel: 6002712

Mr Khaiminlun Tungnung
Member of INTERACT project
C/O Mamang Tungnung
V-11, St. Stephen College
Mukerjee West
New Delhi-7
Tel: 7653630, 7653101
e-mail: tungnung@yahoo.com

Ms Kamal Singh
Mr Girish Rai
Britsih Council
British High Commission
17 K.G Marg
New Delhi -110001
Tel: 3711401
Fax: 3710717
e-mail: kamal.singh@in.britishcouncil.org

Ms Monica Banerjee
National Foundation of India
Core 4 A , Upper Ground Floor
Indian Habitat Centre, Lodhi Road
New Delhi- 23
Tel: 4641865, 4648490-92
e-mail: monica@nfi.org.in

Ms Nayana Bose
External Relation Officer
U.N.H.C.R
14, Jorbagh
New Delhi
Tel: 4699302
e-mail: bose@unhcr.ch

Dr Nisha Gupta
VHAI
Tong Swasthya Bhawan
40 Institutional Area
New Delhi- 6962953, 6518071
Fax: 6853708

Mr Nistula Hebbar
The Week
2/11, INS Building
Rafi Marg
New Delhi
Tel: 3715210
e-mail: nistula@yahoo.com

Mr Omkar Nath
Journalist
D- 57, Panchsheel Enclave
New Delhi- 17
Tel: 6494748

Dr Punyadhar Das
Guwahati Medical College
Prof. & Head of Dept. of Psychology
Bhangagar, Guwahati-781032
Assam
Tel: 0361- 223717®
e-mail: punyadhardas@rediffmail.com

Ms Poonam Gulalia
Ms Vineeta
Springdales School
Pusa Road
New Delhi
Tel: 5743248

Ms Pamela Bhagat
Women's International
Cross Cultural Exchange
A-157 Defence Colony
New Delhi- 110024
Tel: 5691568, 5669024
e-mail: pambhagat@yahoo.com

Ms Pratiba Miglani
Shubhodaya Centre for Rehabilitation of
Victims of Torture and Violence
Basti Vikas Kendra, Near Hanuman Mandir
Private Colony, Srinivaspuri
New Delhi- 110065
Tel: 5407220

Mr Pankaj Anand
PRIA
42, Tughlakabad Institutional Area
New Delhi- 70
Tel: 6081908, 6088508
Fax: 6080183
e-mail: info@pria.org

Ms Parul Srivastav
NIPCCD
5, Siri Institutional Area
Hauz Khas, New Delhi- 16
Tel: 6963002
Fax: 6851349

Dr Ramani Sundaresan
Ms. Anindita Paul
SANJIVINI
A/6, Satsang Vihar Marg
Qutub Institutional Area
New Delhi
Tel: 6864488, 4311918

Ms Reena Nath
Consultant
J-6, Saket
New Delhi-17
6854270, 6867715
e-mail: reenanath@hotmail.com

Mrs Rashmi Goswami
Ford Foundation
55, Lodi Estate
New Delhi- 23
Tel: 4619441
Fax: 4617738
e-mail: r.goswami@fordfound.org

Mr Rajat Banerji
Amway Opportunity Foundation
A-5, Kailash Colony
New Delhi- 42
Tel: 6205138, 6282781
e-mail: Rajat_Bannerji@amway.com

Dr S.G Sharma
Regional Institute of Medical Science
Lamphelpat Imphal
Manipur- 795004
Tel: 0385- 795004, 310277

Ms Sahba Hussain
OXFAM
G-1/3, Malviya Nagar
New Delhi- 24
Tel: 6286980, 6857052
e-mail: sahbahusain@hotmail.com

Ms Sunita Menon
Ms. Ashraf Patel
PRAVAH
15/10, Kalkaji
New Delhi- 19
Tel: 2622964, 6213918
e-mail: sunitamen77@yahoo.com

Dr Sumona Dasgupta
WISCOMP
India Habitat Centre
Lodhi Road
New Delhi 110003
Tel. – 4648450
Fax – 4648451
E.mail : sumonadg@hotmail.com

RGF
Mr M.M. Malhoutra
Secretary General
Rajiv Gandhi Foundation
Tel: 3755128, 3755118, 3716450
E-mail: moni.malhoutra@rgfindia.com

Dr Niraj Seth
Senior Programme Officer
Rajiv Gandhi Foundation
Tel: 3755117,3755118,3755128
Fax: 3755119
E-mail: niraj@rgfindia.com

Ms Mayura Bhatia
Programme Assistant
Rajiv Gandhi Foundation
Tel: 3755117,3755118,3755128
Fax: 3755119
E-mail : dpw@rgfindia.com

Ms Roopee Sahaee
Programme Assistant
Rajiv Gandhi Foundation
Tel: 3755117,3755118,3755128
Fax: 3755119
E-mail : literacy@rgfindia.com

Annex D

ADDRESSING THE MENTAL HEALTH CONCERNS OF PEOPLE AFFECTED BY TERRORISM

Date : November 20, 2001.

Agenda and Time Table

9.30 a.m.–10 a.m.	–	Registration and Tea
10.00 a.m.–10.05 a.m.	–	Welcome by Mr. Manmohan Malhoutra, Secretary General, RGF
10.05 a.m.–10.15 a.m.	–	RGF's Mental Health Programme : Introduction by Ms Niraj Seth, Senior Programme Officer, RGF.

Session I 10.15 a.m.–10.45 a.m.

Mental Health of People Affected by Terrorism
Chairperson : Mr M.M. Malhoutra

Introductory Remarks:

- Dr Pradeep Agrawal, Sr Psychiatrist, LHMC; Delhi.
- Dr K. Krishnamurthy, Institute of Mental Health, Hyderabad

10.45 a.m.–11a.m. Comments/Questions

11 a.m –11.15 a.m. – Tea

Session II 11.15 a.m.–12 noon.

Different Approaches to Mental Health Interventions
Chairperson: Justice J.S.Verma, Chairman, National Human Rights Commission

Paper presentations by

- Dr Shobna Sonpar, Clinical Psychologist
- Ms Arvinder J. Singh, Counsellor
- Dr Sibyl Jade Pena, Medical Doctor, Medecins Sans Frontieres

12 noon–1.00 p.m. Discussions

1 p.m.–2 p.m. – Lunch for participants

Session III 2.p.m.–2.45 p.m.

The role of civil society in addressing mental health concerns
Chairperson – Dr Kiran Bedi, Joint Commissioner of Police

Paper presentations by:

- Dr P. Ngully, Naga People's Movement for Human Rights, Nagaland
- Mrs S. Handa, Principal, DAV School, Batala, Punjab
- Ms Sofiya Hassan Mir, Better World, Srinagar

2.45 p.m.–3.15 p.m. – Discussions

Concluding Session 3.15 p.m.–4.00 p.m.
Chairperson – Dr R.N.Salhan, Ministry of Health
The way forward – Presentation by Ms. Niraj Seth, RGF

4 p.m.–4.30 p.m. – Discussions.